

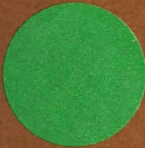
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Loss of Information

**LEGISLATIVE HISTORY
TITLES I-XX
OF THE
SOCIAL SECURITY ACT**

**Volume XXII
99th Congress
1985-1986
Part 1**



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v.22, pt.1

**Legislative History of
Titles I-XX
of the Social Security Act**

**Volume XXII
99th Congress
1985-1986**

Part 1

**Compiled by the
Technical Documents Branch
Division of Technical Documents and Privacy
Office of Regulations
Office of Policy
Social Security Administration**

PREFACE

This legislative history has been prepared to provide a convenient reference source for studies of the development of the provisions of the Social Security Act as amended by the 99th Congress.

The legislative history began with the Social Security Act, as enacted on August 14, 1935, and pertained only to the benefit programs (titles II, XVI, and XVIII) administered by the Social Security Administration. Beginning with the legislative history of the 95th Congress, the history has been expanded to include the 20 titles of the Social Security Act.

This legislative history includes:

- . Every enactment of the 99th Congress amending the Social Security Act.
- . Relevant committee reports of the House of Representatives and the Senate relating to the Social Security Act together with the Conference Reports.

Excerpts were substituted for the full text where pertinent.

In some instances the reports accompanying a particular public law will not reflect one or more provisions contained in the Act. This may be due to the fact that the particular provision was added to the bill on the floor of the House, or Senate, as the case may be, after issuance of the particular report or the particular subject matter involved simply was not included in the report of the committee proceedings. In these cases, background material relating to the amendment may be found in the Congressional Record report of the House or Senate debate on the bill. The Congressional Record may also provide a useful supplemental reference source even in those cases in which the House or Senate report discusses the particular provision in which the researcher is interested. The last page of each public law included in this legislative history contains information about other source materials relating to these provisions that are available.

<p>The material included in this legislative history is an exact photo-reproduction of the original documents.</p>
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Finder's Aid
P.L. 99-53 (99 Stat. 93) Approved June 17, 1985
Authority for Additional Federal Employee Health Benefit Plans

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>99 Stat.</u>	<u>H.Rep. 99-72</u>
Medicare - Payment of Premiums - Federal Employee Health Benefits (conforming amendment)	1840(d)(1)	2(g)	94	2, 6, 14

Public Law 99-53
99th Congress

An Act

To amend title 5, United States Code, to provide that employee organizations which are not eligible to participate in the Federal employees health benefits program solely because of the requirement that applications for approval be filed before January 1, 1980, may apply to become so eligible, and for other purposes.

June 17, 1985

[H.R. 873]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. AUTHORITY FOR ADDITIONAL EMPLOYEE ORGANIZATION PLANS.

Government organization and employees. Health and medical care.

(a) **DEFINITION OF AN EMPLOYEE ORGANIZATION.**—Section 8901(8) of title 5, United States Code, is amended to read as follows:

“(8) ‘employee organization’ means—

“(A) an association or other organization of employees which is national in scope, or in which membership is open to all employees of a Government agency who are eligible to enroll in a health benefits plan under this chapter and which, after December 31, 1978, and before January 1, 1980, applied to the Office for approval of a plan provided under section 8903(3) of this title; and

“(B) an association or other organization which is national in scope, in which membership is open only to employees, annuitants, or former spouses, or any combination thereof, and which, during the 90-day period beginning on the date of enactment of section 8903a of this title, applied to the Office for approval of a plan provided under such section;”

Infra.

(b) **AUTHORITY FOR ADDITIONAL PLANS.**—

(1) Title 5, United States Code, is amended by inserting after section 8903 the following:

“§ 8903a. Additional health benefits plans

5 USC 8903a.

“(a) In addition to any plan under section 8903 of this title, the Office of Personnel Management may contract for or approve one or more health benefits plans under this section.

Contracts.

“(b) A plan under this section may not be contracted for or approved unless it—

Contracts.

“(1) is sponsored or underwritten, and administered, in whole or substantial part, by an employee organization described in section 8901(8)(B) of this title;

Supra.

“(2) offers benefits of the types named by paragraph (1) or (2) of section 8904 of this title or both;

“(3) provides for benefits only by paying for, or providing reimbursement for, the cost of such benefits (as provided for under paragraph (1) or (2) of section 8903 of this title) or a combination thereof; and

“(4) is available only to individuals who, at the time of enrollment, are full members of the organization and to members of their families.

Contracts.

"(c) A contract for a plan approved under this section shall require the carrier—

"(1) to enter into an agreement approved by the Office with an underwriting subcontractor licensed to issue group health insurance in all the States and the District of Columbia; or

"(2) to demonstrate ability to meet reasonable minimum financial standards prescribed by the Office.

"(d) For the purpose of this section, an individual shall be considered a full member of an organization if such individual is eligible to exercise all rights and privileges incident to full membership in such organization (determined without regard to the right to hold elected office)."

(2) The analysis for chapter 89 of title 5, United States Code, is amended by inserting after the item relating to section 8903 the following:

"8903a. Additional health benefits plans."

SEC. 2. TECHNICAL AND CONFORMING AMENDMENTS.

98 Stat. 3203.

(a) Sections 8902(a), 8902(e), 8902(i), 8905(a), 8905(c)(1), 8905(f), 8908(b), and 8913(b) of title 5, United States Code, are each amended by striking out "8903 of this title" and inserting in lieu thereof "8903 or 8903a of this title".

(b) Section 8903(3) of title 5, United States Code, is amended by striking out "employee organizations," and inserting in lieu thereof "employee organizations described in section 8901(8)(A) of this title."

(c) Section 8905(f) of title 5, United States Code, is further amended by striking out "plan described by that section" and inserting in lieu thereof "such plan".

(d) Section 8907(a) of title 5, United States Code, is amended by striking out "section 8903" and inserting in lieu thereof "sections 8903 and 8903a".

(e) Section 8909(d) of title 5, United States Code, is amended—

(1) by inserting "or 8903a" before "of this title"; and

(2) by adding at the end thereof the following: "If the successor organization is an organization described in section 8901(8)(B) of this title, any employee, annuitant, or former spouse so transferred may not remain enrolled in the plan after the end of the contract term in which the merger occurs unless that individual is a full member of such organization (as determined under section 8903a(d) of this title)."

(f) Section 8909(e) of title 5, United States Code, is amended by inserting "or 8903a" before "of this title".

(g) Section 1840(d)(1) of the Social Security Act is amended by inserting "or 8903a" after "8903".

Contracts.

42 USC 1395s.

SEC. 3. INSURANCE COVERAGE FOR RESTORED DISABILITY ANNUITANTS.

(a) HEALTH INSURANCE.—

(1) Section 8908 of title 5, United States Code, is amended by adding at the end thereof the following:

"(c) A disability annuitant whose disability annuity under section 8337 of this title was terminated and is later restored under the second or third sentence of subsection (e) of such section may, under regulations prescribed by the Office, enroll in a health benefits plan described by section 8903 or 8903a of this title if such annuitant was covered by any such plan immediately before such annuity was terminated."

Ante, p. 93.

(2)(A) The section heading for section 8908 of title 5, United States Code, is amended to read as follows:

“§ 8908. Coverage of restored employees and survivor or disability annuitants”.

(B) The analysis for chapter 89 of title 5, United States Code, is amended by striking out the item relating to section 8908 and inserting in lieu thereof the following:

“8908. Coverage of restored employees and survivor or disability annuitants.”.

(b) **LIFE INSURANCE.**—Section 8706 of title 5, United States Code, is amended by adding at the end thereof the following:

98 Stat. 351.

“(g) If the insurance of a former employee receiving a disability annuity under section 8337 of this title stops because of the termination of such annuity, and such annuity is thereafter restored under the second or third sentence of subsection (e) of such section, such former employee may, under regulations prescribed by the Office, elect to resume the insurance coverage which was so stopped.”.

(c) **APPLICABILITY; NOTIFICATION REQUIREMENT; CONSTRUCTION.**—

5 USC 8706 note.

(1) The amendments made by this section shall apply with respect to any individual whose disability annuity is or was restored under section 8337(e) of title 5, United States Code, after December 31, 1983.

(2)(A) The Office of Personnel Management shall notify each individual under subparagraph (B) of any rights which such individual may have under section 8706(g) or section 8908(c) of title 5, United States Code, as amended by this section, including any procedures or deadlines which may apply with respect to the exercise of those rights.

Supra; ante,
p. 94.

(B) Notification under this paragraph shall be provided to any individual who, as of the 90th day after the date of enactment of this Act, is receiving a disability annuity which was restored to such individual under section 8337(e) of title 5, United States Code, after December 31, 1983.

(3)(A) Nothing in this section shall be construed to authorize—

(i) coverage under chapter 87 of title 5, United States Code, in the case of any individual who makes an election under section 8706(g) of such title (as amended by this Act), for any period before the date of such election; or

5 USC 8701
et seq.

(ii) coverage under chapter 89 of title 5, United States Code, in the case of any individual who becomes enrolled in a health benefits plan under section 8908(c) of such title (as amended by this Act), for any period before the date as of which such individual becomes so enrolled.

5 USC 8901
et seq.

(B) This paragraph applies with respect to any individual receiving a disability annuity which is or was restored under section 8337(e) of title 5, United States Code, after December 31, 1983, and before the expiration of the 90-day period beginning on the date of enactment of this Act.

Approved June 17, 1985.

LEGISLATIVE HISTORY—H.R. 873:

HOUSE REPORT No. 99-72 (Comm. on Post Office and Civil Service).
CONGRESSIONAL RECORD, Vol. 131 (1985):
May 13, considered and passed House.
June 3, considered and passed Senate.

AUTHORITY FOR ADDITIONAL FEDERAL EMPLOYEE HEALTH BENEFITS PLANS

MAY 9, 1985.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Ms. OAKAR, from the Committee on Post Office and Civil Service,
submitted the following

REPORT

[To accompany H.R. 873]

[Including cost estimate of the Congressional Budget Office]

The Committee on Post Office and Civil Service, to whom was referred the bill (H.R. 873) to permit Employee Organizations, which are not eligible to participate in the Federal Employees Health Benefits Program solely because of the requirement that applications for approval be filed before January 1, 1980, to apply for approval to offer a health benefits plan, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments are as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. AUTHORITY FOR ADDITIONAL EMPLOYEE ORGANIZATION PLANS.

(a) DEFINITION OF AN EMPLOYEE ORGANIZATION.—Section 8901(8) of title 5, United States Code, is amended to read as follows:

“(8) ‘employee organization’ means—

“(A) an association or other organization of employees which is national in scope, or in which membership is open to all employees of a Government agency who are eligible to enroll in a health benefits plan under this chapter and which, after December 31, 1978, and before January 1, 1980, applied to the Office for approval of a plan provided under section 8903(3) of this title; and

“(B) an association or other organization which is national in scope, in which membership is open only to employees, annuitants, or former spouses, or any combination thereof, and which, during the 90-day period beginning on the date of enactment of section 8903a of this title, applied to the Office for approval of a plan provided under such section;”.

(b) AUTHORITY FOR ADDITIONAL PLANS.—

(1) Title 5, United States Code, is amended by inserting after section 8903 the following:

"§ 8903a. Additional health benefits plans

"(a) In addition to any plan under section 8903 of this title, the Office of Personnel Management may contract for or approve one or more health benefits plans under this section.

"(b) A plan under this section may not be contracted for or approved unless it—

"(1) is sponsored or underwritten, and administered, in whole or substantial part, by an employee organization described in section 8901(8)(B) of this title;

"(2) offers benefits of the types named by paragraph (1) or (2) of section 8904 of this title or both;

"(3) provides for benefits only by paying for, or providing reimbursement for, the cost of such benefits (as provided for under paragraph (1) or (2) of section 8903 of this title) or a combination thereof; and

"(4) is available only to individuals who, at the time of enrollment, are full members of the organization and to members of their families.

"(c) A contract for a plan approved under this section shall require the carrier—

"(1) to enter into an agreement approved by the Office with an underwriting subcontractor licensed to issue group health insurance in all the States and the District of Columbia; or

"(2) to demonstrate ability to meet reasonable minimum financial standards prescribed by the Office.

"(d) For the purpose of this section, an individual shall be considered a full member of an organization if such individual is eligible to exercise all rights and privileges incident to full membership in such organization (determined without regard to the right to hold elected office)."

(2) The analysis for chapter 89 of title 5, United States Code, is amended by inserting after the item relating to section 8903 the following:

"8903a. Additional health benefits plans."

SEC. 2. TECHNICAL AND CONFORMING AMENDMENTS.

(a) Section 8902(a), 8902(e), 8902(i), 8905(a), 8905(c)(1), 8905(f), 8908(b), and 8913(b) of title 5, United States Code, are each amended by striking out "8903 of this title" and inserting in lieu thereof "8903 or 8903a of this title."

(b) Section 8903(3) of title 5, United States Code, is amended by striking out "employee organizations," and inserting in lieu thereof "employee organizations described in section 8901(8)(A) of this title."

(c) Section 8905(f) of title 5, United States Code, is further amended by striking out "plan described by that section" and inserting in lieu thereof "such plan".

(d) Section 8907(a) of title 5, United States Code, is amended by striking out "section 8903" and inserting in lieu thereof "sections 8903 and 8903a".

(e) Section 8909(d) of title 5, United States Code, is amended—

(1) by inserting "or 8903a" before "of this title"; and

(2) by adding at the end thereof the following: "If the successor organization is an organization described in section 8901(8)(B) of this title, any employee, annuitant, or former spouse so transferred may not remain enrolled in the plan after the end of the contract term in which the merger occurs unless that individual is a full member of such organization (as determined under section 8903a(d) of this title)."

(f) Section 8909(e) of title 5, United States Code, is amended by inserting "or 8903a" before "of this title".

(g) Section 1840(d)(1) of the Social Security Act is amended by inserting "or 8903a" after "8903".

SEC. 3. INSURANCE COVERAGE FOR RESTORED DISABILITY ANNUITANTS.

(a) HEALTH INSURANCE.—

(1) Section 8908 of title 5, United States Code, is amended by adding at the end thereof the following:

"(c) A disability annuitant whose disability annuity under section 8337 of this title was terminated and is later restored under the second or third sentence of subsection (e) of such section may, under regulations prescribed by the Office, enroll in a health benefits plan described by section 8903 of 8903a of this title if such annuitant was covered by any such plan immediately before such annuity was terminated."

(2)(A) The section heading for section 8908 of title 5, United States Code, is amended to read as follows:

"8908. Coverage of restored employees and survivor or disability annuitants".

SECTION ANALYSIS

The committee amendment strikes all after the enacting clause and substitutes a new text. The substitute is explained below:

Section 1(a) of the substitute establishes authority for additional employee organization plans. It amends the definition of employee organization under section 8901(8) of title 5, United States Code, to include, under new section 8901(8)(B), national associations or organizations in which membership is open only to employees, annuitants, or former spouses or any combination thereof, and which apply to OPM for approval of a plan during a 90-day period, beginning on the date of enactment.

Section 1(b) of the substitute creates a new section 8903a to establish requirements, in addition to those already established under section 8903, which a new employee organization must meet before its plan may be approved by the OPM.

Section 2 of the the substitute provides for technical and conforming amendments to title 5 of the U.S. Code and to section 1840 of the Social Security Act.

Section 3(a) of the substitute amends section 8908 of title 5 to provide for participation in the FEHBP by an annuitant whose disability annuity was terminated and later restored, who was enrolled in the FEHBP immediately prior to termination of the annuity, and who pays the annuitant's portion of the subscription fee.

Section 3(b) of the substitute amends section 8706 of title 5 to provide for participation in FEGLI by an annuitant whose disability annuity was terminated and later restored, who was enrolled in FEGLI immediately prior to termination of the annuity, and who pays the annuitant's portion of the subscription fee.

Section 3(c)(1) of the substitute provides that section 3 shall apply to any individual whose disability annuity is or was restored after December 31, 1983.

Section 3(c)(2) of the substitute requires OPM to notify certain individuals who may have rights under section 8706(g) or section 8908(c) of those individuals' rights and any procedures or deadlines which may apply with respect to the exercise of those rights.

Section 3(c)(3) of the substitute provides that health insurance or life insurance coverage for those individuals entitled to such coverage under section 3 shall be prospective only.

COST

The cost estimate prepared by the Congressional Budget Office pursuant to section 403 of the Congressional Budget Act of 1974 is set forth below:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, May 8, 1985.

HON. WILLIAM D. FORD,
Chairman, Committee on Post Office and Civil Service,
Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed H.R. 873 as ordered reported by the House Committee on Post Office and Civil Service, May 8, 1985. Based on this review,

TITLE XVII^{*}—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * *

PAYMENT OF PREMIUMS

SEC. 1840. (a) * * *

* * * * *

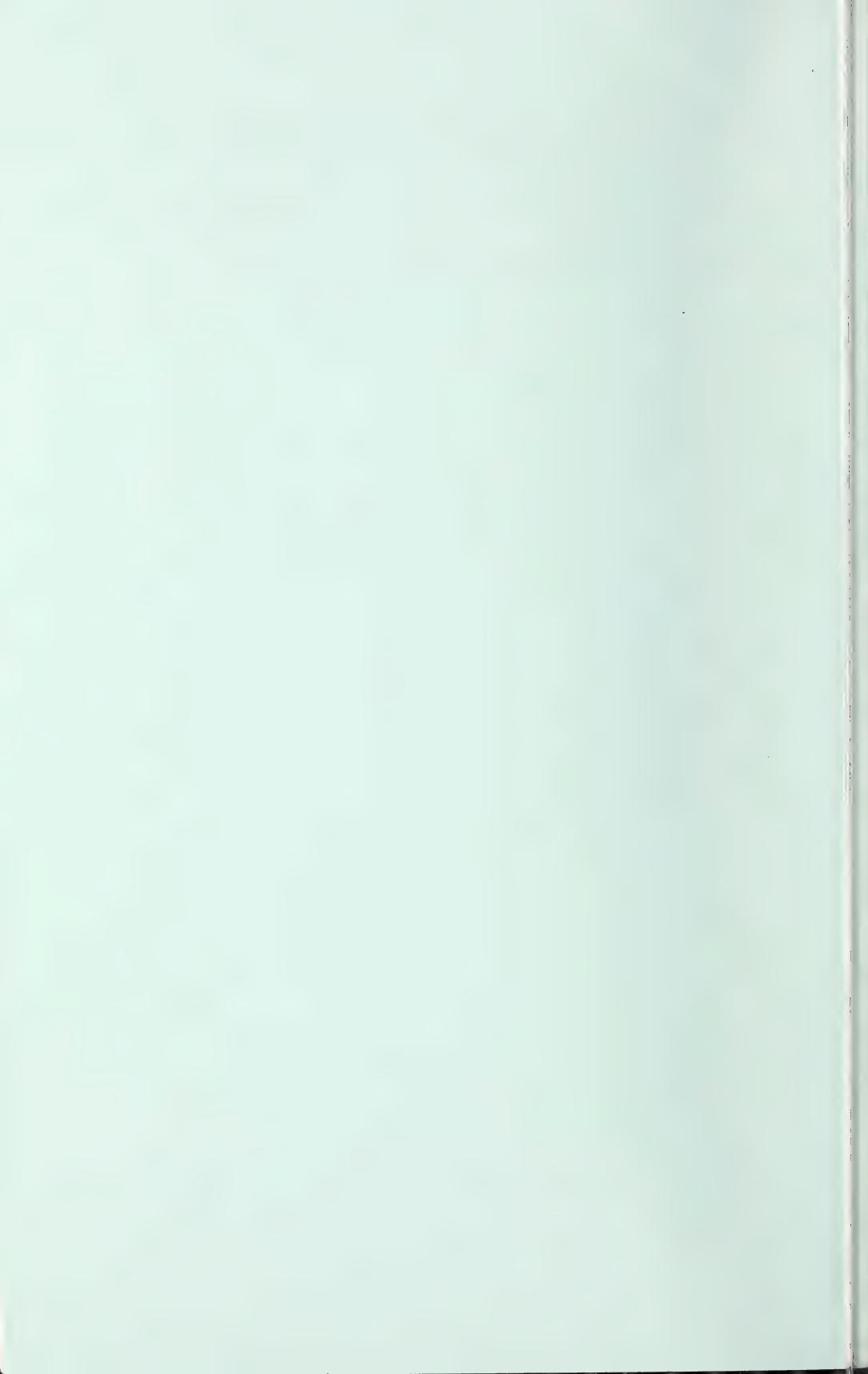
(d)(1) In the case of an individual receiving an annuity under subchapter III of chapter 83 of title 5, United States Code, or any other law administered by the Director of the Office of Personnel Management providing retirement or survivorship protection, to whom neither subsection (a) nor subsection (b) applies, his monthly premiums under this part (and the monthly premiums of the spouse of such individual under this part if neither subsection (a) nor subsection (b) applies to such spouse and if such individual agrees) shall, upon notice from the Secretary of Health and Human Services to the Director of the Office of Personnel Management be collected by deducting the amount thereof from each installment of such annuity. Such deduction shall be made in such manner and at such times as the Director of the Office of Personnel Management may determine. The Director of the Office of Personnel Management shall furnish such information as the Secretary of Health and Human Services may reasonably request in order to carry out his functions under this part with respect to individuals to whom this subsection applies. A plan described in section 8903 or 8903a of title 5, United States Code, may reimburse each annuitant enrolled in such plan an amount equal to the premiums paid by him under this part if such reimbursement is paid entirely from funds of such plan which are derived from sources other than the contributions described in section 8906 of such title.

* * * * *

*Should be Title XVIII of the Social Security Act.

Finder's Aid
P.L. 99-177 (99 Stat. 1037) Approved December 12, 1985
"Increasing the statutory limit on the public debt"

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>99 Stat.</u>	<u>S.Rep. 99-144</u>	<u>H.C.Rep. 99-433</u>	<u>H.C.Rep. 99-351</u>
Trust Fund - Budgeting Treatment	710 [10/1/84- 9/30/92]	261(a)	1093	30	90	--
Trust Fund - Budgeting Treatment	710 [10/1/92 on]	261(b)	1094	30	90	--



***Public Law 99-177**
99th Congress

Joint Resolution

Increasing the statutory limit on the public debt.

Dec. 12, 1985
 [H.J. Res. 372]

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That subsection (b) of section 3101 of title 31, United States Code, is amended by striking out the dollar limitation contained in such subsection and inserting in lieu thereof "\$1,847,800,000,000, or \$2,078,700,000,000 on and after October 1, 1985,".

Ante, p. 814.

SEC. 2. MINIMUM CORPORATE TAX BY CORPORATIONS.

(a) Notwithstanding any other provision of this joint resolution, the Senate Committee on Finance is directed to report to the Senate by July 1, 1986, legislation providing for payment of an alternative minimum corporate tax by corporations on the broadest feasible definition of income to assure that all of those with economic income pay their fair share of taxes: *Provided*, That said alternative minimum corporate tax shall take effect for corporate tax years commencing on or after October 1, 1986. The revenue raised by this tax shall be applied to reduce the Federal deficit.

Report.

Effective date.

(b) Notwithstanding any other provision of this joint resolution, the Committee on Ways and Means is directed to report to the House of Representatives legislation providing for payment of an alternative minimum corporate tax by corporations based upon the broadest feasible definition of income to assure that all of those with economic income pay their fair share of taxes: *Provided*, That, the Committee on Ways and Means shall report such legislation prior to October 1, 1986.

Report.

SEC. 3. ACHILLE LAURO HIJACKING.

(a) The Senate finds that—

(1) the four men identified as the hijackers of the Achille Lauro were responsible for brutally murdering an innocent American citizen, Leon Klinghoffer, and for terrorizing hundreds of innocent crew members and passengers for two days;

Vessels.
 Terrorism.
 Leon
 Klinghoffer.

(2) the United States urges all countries to aid in the swift apprehension, prosecution, and punishment of the terrorists; and

(3) the United States should not tolerate any country providing safe harbor or safe passage to the terrorists.

(b) It is the sense of the Senate that—

(1) the United States demands that no country provide safe harbor or safe passage to these terrorists;

(2) the United States expects full cooperation of all countries in the apprehension, prosecution, and punishment of these terrorists;

(3) the United States cannot condone the release of terrorists or the making of concessions to terrorists; and

(4) the United States identify those individuals responsible for the seizure of the Achille Lauro and the cold-blooded murder of

*Note: The printed text of Public Law 99-177 is a reprint of the hand enrollment, signed by the President on December 12, 1985.

Leon Klinghoffer, as well as those countries and groups that aid and abet such terrorist activities, and take the strongest measures to ensure that those responsible for this brutal act against an American citizen are brought to justice.

TITLE II—DEFICIT REDUCTION PROCEDURES

SEC. 200. SHORT TITLE AND TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This title may be cited as the “Balanced Budget and Emergency Deficit Control Act of 1985”.

(b) **TABLE OF CONTENTS.**—

Sec. 200. Short title and table of contents.

PART A—CONGRESSIONAL BUDGET PROCESS

Subpart I—Congressional Budget

Sec. 201. Congressional budget.

Subpart II—Amendments to Title IV of the Congressional Budget Act of 1974

Sec. 211. New spending authority.

Sec. 212. Credit authority.

Sec. 213. Description by Congressional Budget Office.

Sec. 214. General Accounting Office study; off-budget agencies; member user group.

Subpart III—Additional Provisions to Improve Budget Procedures

Sec. 221. Congressional Budget Office.

Sec. 222. Current services budget for congressional budget purposes.

Sec. 223. Study of off-budget agencies.

Sec. 224. Changes in functional categories.

Sec. 225. Jurisdiction of Committee on Government Operations.

Sec. 226. Continuing study of congressional budget process.

Sec. 227. Early election of committees of the House.

Sec. 228. Rescissions and transfers in appropriation bills.

Subpart IV—Technical and Conforming Amendments

Sec. 231. Table of contents.

Sec. 232. Additional technical and conforming amendments.

PART B—BUDGET SUBMITTED BY THE PRESIDENT

Sec. 241. Submission of President's budget; maximum deficit amount may not be exceeded.

Sec. 242. Supplemental budget estimates and changes.

PART C—EMERGENCY POWERS TO ELIMINATE DEFICITS IN EXCESS OF MAXIMUM DEFICIT AMOUNT

Sec. 251. Reporting of excess deficits.

Sec. 252. Presidential order.

Sec. 253. Compliance report by Comptroller General.

Sec. 254. Congressional action.

Sec. 255. Exempt programs and activities.

Sec. 256. Exceptions, limitations, and special rules.

Sec. 257. Definitions.

PART D—BUDGETARY TREATMENT OF SOCIAL SECURITY TRUST FUNDS

Sec. 261. Treatment of trust funds.

PART E—MISCELLANEOUS AND RELATED PROVISIONS

Sec. 271. Waivers and suspensions; rulemaking powers.

Sec. 272. Restoration of trust fund investments.

Sec. 273. Revenue estimates.

Sec. 274. Judicial review.

Sec. 275. Effective dates.

Federal Savings and Loan Insurance Corporation fund (82-4037-0-3-371);

Federal ship financing fund (69-4301-0-3-403);

Federal ship financing fund, fishing vessels (13-4417-0-3-376);

Geothermal resources development fund (89-0206-0-1-271);

Government National Mortgage Association, Guarantees of mortgage-backed securities (86-4238-0-3-371);

Health education loans (75-4307-0-3-553);

Homeowners assistance fund, Defense (97-4090-0-3-051);

Indian loan guarantee and insurance fund (14-4410-0-3-452);

International Trade Administration, Operations and administration (13-1250-0-1-376);

Low-rent public housing, Loans and other expenses (86-4098-0-3-604);

Maritime Administration, War-risk insurance revolving fund (69-4302-0-3-403);

Overseas Private Investment Corporation (71-4030-0-3-151);

Pension Benefit Guaranty Corporation fund (16-4204-0-3-601);

Rail service assistance (69-0122-0-1-401);

Railroad rehabilitation and improvement financing fund (69-4411-0-3-401);

Rural development insurance fund (12-4155-0-3-452);

Rural electric and telephone revolving fund (12-4230-8-3-271);

Rural housing insurance fund (12-4141-0-3-371);

Small Business Administration, Business loan and investment fund (73-4154-0-3-376);

Small Business Administration, Lease guarantees revolving fund (73-4157-0-3-376);

Small Business Administration, Pollution control equipment contract guarantee revolving fund (73-4147-0-3-376);

Small Business Administration, Surety bond guarantees revolving fund (73-4156-0-3-376);

Veterans Administration, Loan guaranty revolving fund (36-4025-0-3-704);

Veterans Administration, National service life insurance fund (36-8132-0-7-701);

Veterans Administration, Service-disabled veterans insurance fund (36-4012-0-3-701);

Veterans Administration, Servicemen's group life insurance fund (36-4009-0-3-701);

Veterans Administration, United States Government life insurance fund (36-8150-0-7-701);

Veterans Administration, Veterans insurance and indemnities (36-0120-0-1-701);

Veterans Administration, Veterans reopened insurance fund (36-4010-0-3-701); and

Veterans Administration, Veterans special life insurance fund (36-8455-0-8-701).

(h) **LOW-INCOME PROGRAMS.**—The following programs shall be exempt from reduction under any order issued under this part:

Aid to families with dependent children (75-0412-0-1-609);

any time during each cost reporting period of the provider any part of which occurs during the effective period of the order, but only (for each such cost reporting period) in the same proportion as the fraction of the cost reporting period that occurs during the effective period of the order.

(C) **EFFECTIVE PERIOD OF ORDER FOR FISCAL YEAR 1986.**—For purposes of this paragraph, the effective period of a sequestration order for fiscal year 1986 is the period beginning on March 1, 1986, and ending on September 30, 1986.

(3) **NO INCREASE IN BENEFICIARY CHARGES IN ASSIGNMENT-RELATED CASES.**—If a reduction in payment amounts is made under paragraph (1) for services for which payment under part B of title XVIII of the Social Security Act is made on the basis of an assignment described in section 1842(b)(3)(B)(ii), in accordance with section 1842(b)(6)(B), or under the procedure described in section 1870(f)(1), of such Act, the person furnishing the services shall be considered to have accepted payment of the reasonable charge for the services, less any reduction in payment amount made pursuant to a sequestration order, as payment in full.

(4) **NO EFFECT ON COMPUTATION OF AAPCC.**—In computing the adjusted average per capita cost for purposes of section 1876(a)(4) of the Social Security Act, the Secretary of Health and Human Services shall not take into account any reductions in payment amounts which have been or may be effected under this part.

(e) **TREATMENT OF CHILD SUPPORT ENFORCEMENT PROGRAM.**—Any order issued by the President under section 252 shall accomplish the full amount of any required reduction in expenditures under sections 455 and 458 of the Social Security Act by reducing the Federal matching rate for State administrative costs under such program, as specified (for the fiscal year involved) in section 455(a) of such Act, to the extent necessary to reduce such expenditures by that amount.

(f) **TREATMENT OF FOSTER CARE AND ADOPTION ASSISTANCE PROGRAMS.**—Any order issued by the President under section 252 shall make the reduction which is otherwise required under the foster care and adoption assistance programs (established by part E of title IV of the Social Security Act) only with respect to payments and expenditures made by States in which increases in foster care maintenance payment rates or adoption assistance payment rates (or both) are to take effect during the fiscal year involved, and only to the extent that the required reduction can be accomplished by applying a uniform percentage reduction to the Federal matching payments that each such State would otherwise receive under section 474 of that Act (for such fiscal year) for that portion of the State's payments which is attributable to the increases taking effect during that year. No State may, after the date of the enactment of this joint resolution, make any change in the timetable for making payments under a State plan approved under part E of title IV of the Social Security Act which has the effect of changing the fiscal year in which expenditures under such part are made.

(g) **FEDERAL PAY.**—

(1) **IN GENERAL.**—For purposes of any order issued under section 252—

(A) Federal pay under a statutory pay system, and
(B) elements of military pay,

42 USC 1395;
42 USC 1395u.
98 Stat. 1093.

42 USC 1395gg.

42 USC 1395mm.

Ante, p. 1072.

98 Stat. 1311,
1312.
42 USC 655, 658.

Ante, p. 1072.

42 USC 670.
State and local
government.

98 Stat. 1167,
3296.
42 USC 674.

42 USC 670.

shall be subject to reduction under an order in the same manner as other administrative expense components of the Federal budget; except that no such order may reduce or have the effect of reducing the rate of pay to which any individual is entitled under any such statutory pay system or the rate of any element of military pay to which any individual is entitled under title 37, United States Code, or any increase in rates of pay which is scheduled to take effect under section 5305 of title 5, United States Code, section 1009 of title 37, United States Code, or any other provision of law.

(2) DEFINITIONS.—For purposes of this subsection:

(A) The term “statutory pay system” shall have the meaning given that term in section 5301(c) of title 5, United States Code.

(B) The term “elements of military pay” means—

(i) the elements of compensation of members of the uniformed services specified in section 1009 of title 37, United States Code,

(ii) allowances provided members of the uniformed services under sections 403a and 405 of such title, and

(iii) cadet pay and midshipman pay under section 203(c) of such title.

(C) The term “uniformed services” shall have the meaning given that term in section 101(3) of title 37, United States Code.

Ante, pp.
636-638.
98 Stat. 2536.
37 USC 405.
37 USC 203.

(h) TREATMENT OF PAYMENTS AND ADVANCES MADE WITH RESPECT TO UNEMPLOYMENT COMPENSATION PROGRAMS.—(1) For purposes of section 252—

(A) any amount paid as regular unemployment compensation by a State from its account in the Unemployment Trust Fund (established by section 904(a) of the Social Security Act),

Ante, p. 1072.

(B) any advance made to a State from the Federal unemployment account (established by section 904(g) of such Act) under title XII of such Act and any advance appropriated to the Federal unemployment account pursuant to section 1203 of such Act, and

42 USC 1104.

(C) any payment made from the Federal Employees Compensation Account (as established under section 909 of such Act) for the purpose of carrying out chapter 85 of title 5, United States Code, and funds appropriated or transferred to or otherwise deposited in such Account,

42 USC 1321.
42 USC 1323.

42 USC 1109.

5 USC 8501
et seq.

shall not be subject to reduction.

(2)(A) A State may reduce each weekly benefit payment made under the Federal-State Extended Unemployment Compensation Act of 1970 for any week of unemployment occurring during any period with respect to which payments are reduced under an order issued under section 252 by a percentage not to exceed the percentage by which the Federal payment to the State under section 204 of such Act is to be reduced for such week as a result of such order.

26 USC 3304
note.

Ante, p. 1072.

(B) A reduction by a State in accordance with subparagraph (A) shall not be considered as a failure to fulfill the requirements of section 3304(a)(11) of the Internal Revenue Code of 1954.

26 USC 3304
note.

26 USC 3304.

(i) TREATMENT OF MINE WORKER DISABILITY COMPENSATION INCREASES AS AUTOMATIC SPENDING INCREASES.—An order issued by the President under section 252 may not result in eliminating or reducing an increase in disability benefits under the Federal Mine Safety and Health Act except in the manner provided for automatic

Ante, p. 1072.

30 USC 801 note.

Ante, p. 1072.

Agriculture and
agricultural
commodities.

sending increases under section 252(a)(1)(A), and no such increase may, pursuant to such section, be reduced below zero.

(j) COMMODITY CREDIT CORPORATION.—

(1) POWERS AND AUTHORITIES OF THE COMMODITY CREDIT CORPORATION.—This title shall not restrict the Commodity Credit Corporation in the discharge of its authority and responsibility as a corporation to buy and sell commodities in world trade, to use the proceeds as a revolving fund to meet other obligations and otherwise operate as a corporation, the purpose for which it was created.

(2) REDUCTION IN PAYMENTS MADE UNDER CONTRACTS.—(A) Payments and loan eligibility under any contract entered into with a person by the Commodity Credit Corporation prior to the time an order has been issued under section 252 shall not be reduced by an order subsequently issued. Subject to subparagraph (B), after an order is issued under such section for a fiscal year, any cash payments made by the Commodity Credit Corporation—

(i) under the terms of any one-year contract entered into in such fiscal year and after the issuance of the order; and

(ii) out of an entitlement account,

to any person (including any producer, lender, or guarantee entity) shall be subject to reduction under the order.

(B) Each contract entered into with producers or producer cooperatives with respect to a particular crop of a commodity and subject to reduction under subparagraph (A) shall be reduced in accordance with the same terms and conditions. If some, but not all, contracts applicable to a crop of a commodity have been entered into prior to the issuance of an order under section 252, the order shall provide that the necessary reduction in payments under contracts applicable to the commodity be uniformly applied to all contracts for the next succeeding crop of the commodity, under the authority provided in paragraph (3).

(3) DELAYED REDUCTION IN OUTLAYS PERMISSIBLE.—Notwithstanding any other provision of this joint resolution, if an order under section 252 is issued with respect to a fiscal year, any reduction under the order applicable to contracts described in paragraph (1) may provide for reductions in outlays for the account involved to occur in the fiscal year following the fiscal year to which the order applies. No other account, or other program, project, or activity, shall bear an increased reduction for the fiscal year to which the order applies as a result of the operation of the preceding sentence.

(4) UNIFORM PERCENTAGE RATE OF REDUCTION AND OTHER LIMITATIONS.—All reductions described in paragraph (2) which are required to be made in connection with an order issued under section 252 with respect to a fiscal year—

(A) shall be made so as to ensure that outlays for each program, project, activity, or account involved are reduced by a percentage rate that is uniform for all such programs, projects, activities, and accounts, and may not be made so as to achieve a percentage rate of reduction in any such item exceeding the rate specified in the order; and

(B) with respect to commodity price support and income protection programs, shall be made in such manner and under such procedures as will attempt to ensure that—

Ante, p. 1072.

year determined under section 3(7) of the Congressional Budget and Impoundment Control Act of 1974.

Ante, p. 1039.

(6) The term “real economic growth”, with respect to any fiscal year, means the growth in the gross national product during such fiscal year, adjusted for inflation, consistent with Department of Commerce definitions.

(7) The terms “sequester” and “sequestration” (subject to section 252(a)(4)) refer to or mean the cancellation of new budget authority, unobligated balances, obligated balances, new loan guarantee commitments, new direct loan obligations, and spending authority as defined in section 401(c)(2) of the Congressional Budget Act of 1974, and the reduction of obligation limitations.

Ante, p. 1072.

Ante, p. 1056.

(8) The term “account” means an item for which appropriations are made in any appropriation Act used to determine the budget base, and, for items not provided for in appropriation Acts, such term means an item for which there is a designated budget account identification code number in the Appendix to the President’s budget.

PART D—BUDGETARY TREATMENT OF SOCIAL SECURITY TRUST FUNDS

SEC. 261. TREATMENT OF TRUST FUNDS.

(a) FISCAL YEARS 1986 THROUGH 1992.—

(1) IN GENERAL.—Section 710 of the Social Security Act (as added by paragraph (1) of subsection (a) of section 346 of the Social Security Amendments of 1983) is amended—

42 USC 911.

(A) by striking out all beginning with “the” the first place it appears down through “Disability Insurance Trust Fund, the” and inserting in lieu thereof “the”;

(B) by striking out the comma after “Hospital Insurance Trust Fund”;

(C) by striking out “sections 1401, 3101, and 3111” and inserting in lieu thereof “sections 1401(b), 3101(b), and 3111(b)”;

(D) by redesignating all after the section designation as subsection (b);

(E) by inserting immediately after the section designation the following:

“(a) The receipts and disbursements of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund, and the taxes imposed under sections 1401(a), 3101(a), and 3111(a) of the Internal Revenue Code of 1954, shall not be included in the totals of the budget of the United States Government as submitted by the President or of the congressional budget and shall be exempt from any general budget limitation imposed by statute on expenditures and net lending (budget outlays) of the United States Government.”; and

Taxes.

(F) by adding at the end thereof the following new subsection:

“(c) No provision of law enacted after the date of the enactment of the Balanced Budget and Emergency Deficit Control Act of 1985 (other than a provision of an appropriation Act that appropriates funds authorized under the Social Security Act as in effect on the date of the enactment of the Balanced Budget and Emergency

26 USC 1401,
3101, 3111.

Prohibition.

42 USC 1305.

Deficit Control Act of 1985) may provide for payments from the general fund of the Treasury to the Federal Old-Age and Survivors Insurance Trust Fund or the Federal Disability Insurance Trust Fund, or for payments from either such Trust Fund to the general fund of the Treasury.”

42 USC 911 note.

(2) APPLICATION.—The amendments made by paragraph (1) shall apply with respect to fiscal years beginning after September 30, 1985, and ending before October 1, 1992.

42 USC 911.

(b) FISCAL YEAR 1993 AND THEREAFTER.—Section 710(a) of the Social Security Act (42 U.S.C. 911 note), as amended by section 346(b) of the Social Security Amendments of 1983 (to be effective with respect to fiscal years beginning after September 30, 1992) is amended—

(1) by inserting “(1)” after the subsection designation; and

(2) by adding at the end thereof the following new paragraph:

“(2) No provision of law enacted after the date of the enactment of the Balanced Budget and Emergency Deficit Control Act of 1985 (other than a provision of an appropriation Act that appropriates funds authorized under the Social Security Act as in effect on the date of the enactment of the Balanced Budget and Emergency Deficit Control Act of 1985) may provide for payments from the general fund of the Treasury to any Trust Fund specified in paragraph (1) or for payments from any such Trust Fund to the general fund of the Treasury.”

42 USC 1305.

PART E—MISCELLANEOUS AND RELATED PROVISIONS

SEC. 271. WAIVERS AND SUSPENSIONS: RULEMAKING POWERS.

2 USC 621 note.

(a) BUDGET ACT WAIVERS IN THE SENATE.—Section 904 of the Congressional Budget Act of 1974 is amended by redesignating subsection (c) as subsection (d), and by inserting after subsection (b) the following new subsection:

Ante, pp. 1047, 1050.

“(c) Sections 305(b)(2) and 306 of this Act may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.”

2 USC 901 note.

(b) OTHER WAIVERS AND SUSPENSIONS IN THE SENATE.—Sections 301(i), 302(f), 304(b), 310(d), 310(g), and 311(a) of the Congressional Budget Act of 1974 may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn. This subsection shall not apply to any joint resolution reported or discharged pursuant to section 254(a) of this joint resolution.

Ante, pp. 1040, 1044, 1047, 1053, 1055.

Ante, p. 1078.
2 USC 901 note.

(c) RULEMAKING POWERS.—The provisions of this title, other than those relating to the activities of the executive and judicial branches of the Government, are enacted by the Congress—

(1) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and as such they shall be considered as part of the rules of each House, respectively, or of that House to which they specifically apply, and such rules shall supersede other rules only to the extent that they are inconsistent therewith; and

(2) with full recognition of the constitutional right of either House to change such rules (so far as relating to such House) at any time, in the same manner and to the same extent as in the case of any other rule of such House.

SEC. 272. RESTORATION OF TRUST FUND INVESTMENTS.

2 USC 901 note.

(a) RESTORATION OF SOCIAL SECURITY TRUST FUNDS AND CERTAIN OTHER FUNDS.—

(1) **REISSUANCE OF OBLIGATIONS.**—The Secretary of the Treasury shall immediately reissue to each fund listed in paragraph (3) obligations under chapter 31 of title 31, United States Code, which are identical, with respect to interest rate and maturity, to public debt obligations held by such fund which—

31 USC 3101
et seq.

(A) were redeemed during the period beginning with September 1, 1985, and ending with September 29, 1985, and

(B) as determined by such Secretary on the basis of standard investment procedures for such fund in effect on September 1, 1985, would not have been redeemed if H.J. Res. 372 (99th Congress, 1st Session), as deemed passed by the House of Representatives on August 1, 1985, had been enacted into law on August 1, 1985.

Ante, p. 1037.

Such obligations shall be substituted for obligations which are held by such fund on the date of the enactment of this joint resolution in a manner which will ensure that, after such substitution, the holdings of such fund will replicate to the maximum extent practicable the holdings which would have been held by such fund on such date if H.J. Res. 372 (99th Congress, 1st Session), as deemed passed by the House of Representatives on August 1, 1985, had been enacted into law on August 1, 1985.

Ante, p. 1037.

(2) **APPROPRIATION TO FUNDS OF INTEREST LOST ON OR AFTER SEPTEMBER 1, 1985.**—The Secretary of the Treasury shall pay on the normal interest payment date to each fund listed in paragraph (3), from amounts in the general fund of the Treasury not otherwise appropriated, an amount determined by such Secretary to be equal to the excess of—

(A) the net amount of interest which would have been earned by such fund, during the period beginning with September 1, 1985, and ending with the date of the enactment of this joint resolution, if all noninvestments, redemptions, and disinvestments with respect to such fund which—

(i) occurred during such period, and

(ii) would not have occurred if H.J. Res. 372 (99th Congress, 1st Session), as deemed passed by the House of Representatives on August 1, 1985, had been enacted into law on August 1, 1985,

Ante, p. 1037.

had not occurred, over

(B) the net amount of interest actually earned by such fund during such period.

(3) **FUNDS AFFECTED.**—The funds referred to in paragraphs (1) and (2) are the following:

(A) the Federal Old-Age and Survivors Insurance Trust Fund,

(B) the Federal Disability Insurance Trust Fund,

(C) the Federal Hospital Insurance Trust Fund,

(D) the Federal Supplementary Medical Insurance Trust Fund,

(E) the Railroad Retirement Account,

(F) the Civil Service Retirement and Disability Fund, and

(G) all other funds (other than the funds referred to in subsection (b) or (c)) listed in Table III of the Monthly Statement of the Public Debt issued by the Department of the Treasury for November 30, 1985.

(b) RESTORATION OF DEPARTMENT OF DEFENSE MILITARY RETIREMENT FUND.—

(1) **ISSUANCE OF OBLIGATIONS.**—The Secretary of the Treasury shall immediately issue to the Department of Defense Military Retirement Fund obligations under chapter 31 of title 31, United States Code, which such Secretary, in consultation with the Secretary of Defense, determines would have been issued to such fund on October 1, 1985, if H.J. Res. 372 (99th Congress, 1st Session), as deemed passed by the House of Representatives on August 1, 1985, had been enacted into law on August 1, 1985. Such obligations shall be market-based special obligations issued at prices, including accrued interest, prevailing for such obligations on October 1, 1985. Such obligations shall be substituted for all obligations which were purchased by such fund during the period beginning with October 1, 1985, and ending with November 14, 1985, with amounts which were transferred to such fund on October 1, 1985.

(2) APPROPRIATION TO FUND OF INTEREST LOST ON OR AFTER OCTOBER 1, 1985.—

(A) **IN GENERAL.**—The Secretary of the Treasury shall immediately pay to the Department of Defense Military Retirement Fund, from amounts in the general fund of the Treasury not otherwise appropriated, an amount determined by such Secretary, in consultation with the Secretary of Defense, to be equal to the excess of—

(i) the interest which would have been earned by such fund during the period beginning with October 1, 1985, and ending with November 14, 1985, if the obligations issued pursuant to paragraph (1) had been issued on October 1, 1985, over

(ii) the amount of interest actually collected by such fund during such period on obligations purchased by such fund with amounts which were transferred to such fund on October 1, 1985.

(B) **INVESTMENT OF INTEREST RECEIPTS.**—The Secretary of the Treasury shall immediately invest the amount paid to the Department of Defense Military Retirement Fund pursuant to subparagraph (A) in obligations designated by the Secretary of Defense. Such obligations shall be market-based special obligations issued with an issue date of November 15, 1985, and at prices, including accrued interest, prevailing for such obligations on November 15, 1985.

(c) APPROPRIATION TO CERTAIN FUNDS WITH RESPECT TO UNINVESTED BALANCES AFTER DECEMBER 6, 1985.—

(1) **IN GENERAL.**—The Secretary of the Treasury shall immediately pay, from amounts in the general fund not otherwise appropriated, to each fund which is listed in Table III of the Monthly Statement of the Public Debt issued by the Department of the Treasury for November 30, 1985, and which invests in market-based special obligations under chapter 31 of title 31, United States Code, an amount equal to the interest which would have been earned by such fund during the period begin-

31 USC 3101
et seq.

Ante, p. 1037.

31 USC 3101
et seq.

(B) The amendment made by section 212 shall become effective February 1, 1986. *Ante*, p. 1058.

(b) EXPIRATION.—

(1) Part C of this title, and the other provisions contained in or added by this title which are listed in paragraph (2), shall expire September 30, 1991. *Ante*, p. 1063.

(2) The other provisions referred to in paragraph (1) are as follows:

(A) section 3(7) of the Congressional Budget and Impoundment Control Act of 1974 and the second sentence of section 3(6) of such Act (as added by section 201(a)(1) of this joint resolution); *Ante*, p. 1039.

(B) sections 301(i) and 304(b) of the Congressional Budget Act of 1974 and the portion of section 311(a) of such Act which begins with “or, in the Senate” and ends with “paragraph (2) of such subsection)” (as added by section 201(b) of this joint resolution); *Ante*, p. 1040, 1047, 1050.

(C) sections 1105(f) and 1106(c) of title 31, United States Code (as added by sections 241(b) and 242(b) of this joint resolution); and *Ante*, p. 1063.

(D) section 271(b) of this joint resolution. *Ante*, p. 1094.

(c) OASDI TRUST FUNDS.—The amendments made by part D shall apply as provided in such part. *Ante*, p. 1093.

Approved December 12, 1985.

LEGISLATIVE HISTORY—H.J. Res. 372:

HOUSE REPORTS: No. 99-351 (Comm. of Conference) and No. 99-433 (Comm. of Conference).

SENATE REPORT No. 99-144 (Comm. on Finance).

CONGRESSIONAL RECORD, Vol. 131 (1985):

Aug. 1, Sept. 4, considered and passed House.

Oct. 3-6, 8-10, considered and passed Senate, amended.

Nov. 1, House receded and concurred in Senate amendment and in others with amendments.

Nov. 1, 4-6, Senate agreed to conference report; concurred in House amendments with amendments.

Nov. 6, House disagreed to Senate amendments.

Nov. 7, Senate insisted on amendments, agreed to further conference.

Dec. 11, House and Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 21, No. 50 (1985):

Dec. 12, Presidential statement.



INCREASE OF PERMANENT PUBLIC DEBT LIMIT

SEPTEMBER 26 (legislative day, SEPTEMBER 23), 1985.—Ordered to be printed

Mr. PACKWOOD, from the Committee on Finance,
submitted the following

R E P O R T

together with

ADDITIONAL VIEWS

[To accompany H.J. Res. 372]

The Committee on Finance, to which was referred the bill (H.J. Res. 372) to increase the permanent public debt limit, having considered the same, reports favorably thereon without amendment, and recommends that the bill do pass.

I. SUMMARY

H.J. Res. 372 provides initially for an increase of \$24 billion in the permanent debt limit from \$1,823.8 billion to \$1,847.8 billion, which would become effective on enactment.

An additional increase of \$230.9 billion which would raise the permanent public debt limit to \$2,078.7 billion would go into effect on October 1, 1985.

The debt limit levels in this bill are the amounts approved by the Congress in the Conference Report on the Budget Resolution for fiscal year 1986 (S. Con. Res. 32).

support the difficult measures necessary to sharply reduce federal spending and deficits.

Congress does not have to wait until the next budget cycle to take action. It has the power to act today. In addition to needed procedural reforms, coming appropriations and reconciliation bills provide a golden opportunity to reduce federal spending beyond what the budget resolution requires. Until this is done, I see no reason why the American taxpayers should bear the burden of \$255 billion more federal debt.

WILLIAM L. ARMSTRONG.

APPENDIX TO SENATOR ARMSTRONG'S VIEWS

I. The following table reviews the growth in the federal debt:

Year	Gross federal debt	Public debt	Debt subject to limit
1940.....	\$50.6	\$42.7	\$43.2
1950.....	256.8	219.0	255.3
1960.....	290.8	237.2	283.8
1970.....	382.6	284.8	372.6
1975.....	544.1	396.9	534.2
1980.....	914.3	715.1	908.7
1981.....	1,003.9	794.4	998.8
1982.....	1,146.9	929.4	1,142.9
1983.....	1,381.9	1,141.7	1,337.9
1984.....	1,576.7	1,312.6	1,572.9
1985.....	1,844.3	1,515.2	1,840.6
1986.....	2,076.9	1,694.7	2,073.4

DEFINITIONS

Gross Federal Debt.—is composed of debt owned by the public and debt held by Federal Government accounts. Government accounts that hold debt are predominately social insurance trust funds: Social Security, Medicare, Civil Service Retirement, Military Retirement, and Unemployment. Income into these accounts not needed for current benefits is used to purchase Treasury Securities, or, in effect, loaned to the general fund.

Public Debt.—Federal debt held by the public is all debt excluding that held by government accounts. The "public" includes any person or institution other than the Federal Government, for example, individuals, private banks, insurance companies, the Federal Reserve Banks, and foreign central banks.

Debt Subject to Limit.—This is the amount of federal debt the Treasury is authorized to borrow up to. Since the beginning of the Republic, Congress has authorized a specific amount of debt for each separate issue. Beginning with the Second Liberty Bond Act of 1917 and subsequent amendments the current statutory debt ceiling was established. This amount includes nearly all Gross Federal Debt. A small amount not included consists of certain certificates no longer issued and a small portion of agency debt.

II. Historical and projected Federal spending:

CONFERENCE SUBSTITUTE, 1ST BUDGET RESOLUTION, FISCAL YEAR 1986

[in billions of dollars]

31

	1960	1970	1980	1981	1982	1983	1984	1985	1986	1987	1988
Federal spending:											
National defense.....	45.2	78.6	134.0	157.5	185.3	209.9	227.4	249.40	267.10	285.20	303.90
International affairs.....	3.0	4.3	12.7	13.1	12.3	11.8	13.9	17.20	18.85	17.30	16.45
Space and technology.....	.6	4.5	5.8	6.5	7.2	7.9	8.3	8.70	8.90	8.95	9.00
Energy.....	.5	1.0	10.2	15.2	13.5	9.4	7.1	5.50	5.55	4.45	4.45
Natural resources.....	1.6	3.1	13.9	13.6	12.0	12.7	12.6	13.00	13.00	12.75	12.95
Agriculture.....	2.6	5.2	8.8	11.3	15.9	22.9	13.6	23.30	15.55	16.25	13.75
Commerce and housing cr.....	1.6	2.1	9.4	8.2	6.3	6.7	6.9	5.50	3.70	3.45	5.20
Transportation.....	4.1	7.0	21.3	23.4	20.6	21.3	22.7	26.00	25.80	27.70	28.10
Community development.....	.2	2.4	11.3	10.6	8.3	7.6	7.7	8.40	8.05	7.30	6.85
Social services and education.....	1.0	8.6	31.8	33.7	27.0	26.6	27.6	30.40	30.85	31.35	32.10
Health.....	.8	13.1	23.2	26.9	27.4	28.6	30.4	33.50	34.90	37.80	40.70
Medicare.....		6.0	32.0	42.0	46.6	52.6	57.5	65.90	69.20	76.40	84.90
Income security.....	18.8	48.1	86.5	99.7	107.7	122.6	112.7	128.90	119.05	123.80	129.80
Social Security.....	11.4	30.0	119.0	139.6	156.0	170.7	178.2	189.00	200.80	214.00	228.10
Veterans.....	5.4	8.7	21.2	23.0	24.0	24.8	25.6	26.40	26.80	27.25	27.65
Justice.....	.4	1.0	4.6	4.8	4.7	5.1	5.7	6.30	6.80	7.00	7.15
General Government.....	1.0	1.9	4.4	4.6	4.5	4.8	5.1	5.70	5.45	5.20	5.45
General purpose funds.....	.2	.5	8.6	6.9	6.4	6.5	6.8	6.40	6.50	3.20	2.10
Interest.....	8.3	18.3	52.5	68.7	85.0	89.8	111.1	129.20	142.30	152.50	155.00
Allowances.....									-1.65	-1.70	-50
Offsetting receipts.....	-2.5	-6.6	-19.9	-28.0	-26.1	-34.0	-32.0	-32.40	-39.90	-37.10	-40.90
Total.....	92.2	196.6	590.9	678.2	745.7	808.3	851.8	946.30	967.60	1,023.75	1,072.20
Budget receipts.....	92.5	193.7	520.0	599.3	617.8	600.6	666.5	736.50	795.50	869.40	960.10
Surplus/deficit.....	+3	-2.8	-73.8	-78.9	-127.9	-207.8	-185.3	-209.80	-171.90	-154.35	-112.10

CONFERENCE SUBSTITUTE, 1ST BUDGET RESOLUTION, FISCAL YEAR 1986—Continued

(in billions of dollars)

	1960-69	1970-79	1980	1981	1982	1983	1984	SBC 1985	SBC 1986	SBC 1987	SBC 1988
U.S. economy:											
Real GNP growth.....	3.9	3.5	-0.4	-1.9	-0.9	5.5	6.8	3.9	4.0	4.0	4.0
Unemployment.....	4.8	6.2	7.0	7.5	9.5	9.9	7.5	7.1	7.0	6.7	6.4
Interest rate (T-bill).....	3.96	6.27	11.5	14.1	10.7	8.6	9.6	8.1	7.9	7.2	5.9
Inflation (GNP deflator).....	2.33	7.1	13.5	10.4	5.9	4.6	3.4	4.1	4.3	4.2	3.9

Source: Senate Budget Committee, Aug. 1, 1985.

INCREASE IN DEBT LIMIT

NOVEMBER 1, 1985.—Ordered to be printed

Mr. ROSTENKOWSKI, from the committee of conference, submitted in disagreement the following

CONFERENCE REPORT

[To accompany H.J. Res. 372]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the joint resolution (H.J. Res. 372) increasing the statutory limit on the public debt, having met, after full and free conference, have been unable to agree.

From the Committee on Ways and Means:

DAN ROSTENKOWSKI,
SAM M. GIBBONS,
J.J. PICKLE,
C.B. RANGEL,
PETE STARK,
JAMES JONES,
ED JENKINS,
RICHARD GEPHARDT,
MARTY RUSSO,
JOHN J. DUNCAN,
BILL ARCHER
GUY VANDER JAGT,
PHILIP M. CRANE,
BILL FRENZEL,

From the Committee on Appropriations:

JAMIE WHITTEN,
EDWARD P. BOLAND,
WILLIAM H. NATCHER,
NEAL SMITH,
C. PURSELL,
TOM LOEFFLER,

From the Committee on Rules:

CLAUDE PEPPER,
JOE MOAKLEY,
BUTLER DERRICK,
ANTHONY C. BEILENSEN,
MARTIN FROST,
DELBERT LATTI,
TRENT LOTT,

From the Committee on the Budget:

WILLIAM H. GRAY,
GEORGE MILLER,
MARVIN LEATH,
JACK KEMP,

From the Committee on Government Operations:

JACK BROOKS,
DON FUQUA,
HENRY WAXMAN,
MIKE SYNAR,
FRANK HORTON,
THOMAS N. KINDNESS,

As additional conferees:

THOMAS S. FOLEY,
DAVID OBEY,
M.R. OAKAR,
LEON PANETTA,
VIC FAZIO,
ROBERT H. MICHEL,
DICK CHENEY,
LYNN MARTIN,
CONNIE MACK,

Managers on the Part of the House.

BOB PACKWOOD,
BILL ROTH,
PETE V. DOMENICI,
J.C. DANFORTH,
W.L. ARMSTRONG,
RUSSELL B. LONG,
LLOYD BENTSEN,
LAWTON CHILES,
CARL LEVIN,

Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendments of the Senate to the joint resolution (H.J. Res. 372), increasing the statutory limit on the public debt, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report.

From the Committee on Ways and Means:

DAN ROSTENKOWSKI,
SAM M. GIBBONS,
J.J. PICKLE,
C.B. RANGEL,
PETE STARK,
JAMES JONES,
ED JENKINS,
RICKARD GEPHARDT,
MARTY RUSSO,
JOHN J. DUNCAN,
BILL ARCHER,
GUY VANDER JAGT,
PHILIP M. CRANE,
BILL FRENZEL,

From the Committee on Appropriations:

JAMIE WHITTEN,
EDWARD P. BOLAND,
WILLIAM H. NATCHER,
NEAL SMITH,
C. PURSELL,
TOM LOEFFLER,

From the Committee on Rules:

CLAUDE PEPPER,
JOE MOAKLEY,
BUTLER DERRICK,
ANTHONY C. BEILINSON,
MARTIN FROST,
DELBERT LATTA,
TRENT LOTT,

From the Committee on the Budget:

WILLIAM H. GRAY,
GEORGE MILLER,
MARVIN LEATH,
JACK KEMP,

From the Committee on Government Operations:

JACK BROOKS,
DON FUQUA,
HENRY WAXMAN,
MIKE SYNAR,
FRANK HORTON,
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As additional conferees:

THOMAS S. FOLEY,
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DICK CHENEY,
LYNN MARTIN,
CONNIE MACK,

Managers on the Part of the House.

BOB PACKWOOD,
BILL ROTH,
PETE V. DOMENICI,
J.C. DANFORTH,
W.L. ARMSTRONG,
RUSSELL B. LONG,
LLOYD BENTSEN,
LAWTON CHILES,
CARL LEVIN,

Managers on the Part of the Senate.



INCREASING THE STATUTORY LIMIT ON THE PUBLIC DEBT

DECEMBER 10, 1985.—Ordered to be printed

Mr. ROSTENKOWSKI, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.J. Res. 372]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the amendments of the House of Representatives to the amendments of the Senate numbered 1 and 2 to the joint resolution (H.J. Res. 372) increasing the statutory limit on the public debt, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its amendment to part (2) of the amendment of the House to the amendment of the Senate numbered 1.

Amendment numbered 2:

That the House recede from its disagreement to the amendment of the Senate to the amendment of the House to the amendment of the Senate numbered 2, and agree to the same with an amendment as follows:

In lieu of inserting the matter proposed to be inserted by the Senate amendment, insert the following at the end of the joint resolution:

TITLE II—DEFICIT REDUCTION PROCEDURES

SEC. 200. SHORT TITLE AND TABLE OF CONTENTS.

(a) *SHORT TITLE.*—This title may be cited as the “Balanced Budget and Emergency Deficit Control Act of 1985”

(b) *TABLE OF CONTENTS.*—

Sec. 200. Short title and table of contents.

PART A—CONGRESSIONAL BUDGET PROCESS

Subpart I—Congressional Budget

Sec. 201. Congressional budget.

Subpart II—Amendments to Title IV of the Congressional Budget Act of 1974

Sec. 211. New spending authority.

Sec. 212. Credit authority.

Sec. 213. Description by Congressional Budget Office.

Sec. 214. General Accounting Office study; off-budget agencies; member user group.

Subpart III—Additional Provisions to Improve Budget Procedures

Sec. 221. Congressional Budget Office.

Sec. 222. Current services budget for congressional budget purposes.

Sec. 223. Study of off-budget agencies.

Sec. 224. Changes in functional categories.

Sec. 225. Jurisdiction of Committee on Government Operations.

Sec. 226. Continuing study of congressional budget process.

Sec. 227. Early election of committees of the House.

Sec. 228. Rescissions and transfers in appropriation bills.

Subpart IV—Technical and Conforming Amendments

Sec. 231. Table of contents.

Sec. 232. Additional technical and conforming amendments.

PART B—BUDGET SUBMITTED BY THE PRESIDENT

Sec. 241. Submission of President's budget; maximum deficit amount may not be exceeded.

Sec. 242. Supplemental budget estimates and changes.

PART C—EMERGENCY POWERS TO ELIMINATE DEFICITS IN EXCESS OF MAXIMUM DEFICIT AMOUNT

Sec. 251. Reporting of excess deficits.

Sec. 252. Presidential order.

Sec. 253. Compliance report by Comptroller General.

Sec. 254. Congressional action.

Sec. 255. Exempt programs and activities.

Sec. 256. Exceptions, limitations, and special rules.

Sec. 257. Definitions.

PART D—BUDGETARY TREATMENT OF SOCIAL SECURITY TRUST FUNDS

Sec. 261. Treatment of trust funds.

PART E—MISCELLANEOUS AND RELATED PROVISIONS

Sec. 271. Waivers and suspensions; rulemaking powers.

Sec. 272. Restoration of trust fund investments.

Sec. 273. Revenue estimates.

Sec. 274. Judicial review.

Sec. 275. Effective dates.

PART A—CONGRESSIONAL BUDGET PROCESS

Subpart I—Congressional Budget

SEC. 201. CONGRESSIONAL BUDGET.

(a) DEFINITIONS.—

(1) Section 3 of the Congressional Budget and Impoundment Control Act of 1974 is amended by adding at the end thereof the following new paragraphs:

“(6) The term ‘deficit’ means, with respect to any fiscal year, the amount by which total budget outlays for such fiscal year

IV. TREATMENT OF PROGRAMS

a. Low-Income Programs

House Amendment

The House amendment exempts from reduction the following programs: food stamps, supplemental security income, aid to families with dependent children, child nutrition, veterans compensation and pensions, community health centers, migrant health, and WIC.

Senate Amendment

No comparable provision.

Conference Agreement

The conference agreement exempts the following low-income programs: aid to families with dependent children, child nutrition, food stamp programs, medicaid, supplemental security income, and WIC. Special rules are established for certain health programs including community health centers, migrant health centers, Indian health facilities, Indian health services and Veterans' medical care (see discussion below).

b. General Exemptions

House Amendment

The House amendment exempts from any sequester order social security tier I railroad retirement COLA's; outlays for net interest; and payments for the earned income tax credit. The House version also exempts from reduction claims and judgement against the government; salaries of judges (except future increases); compensation of the President; any legal obligations of federal credit guarantee and insurance programs; payments to trust funds; funds held for other governments and entities; federal financing operations, including offsetting receipts and collections; outlays resulting from private donations, bequests or voluntary contributions to the government; and intragovernmental funds.

Senate Amendment

The Senate amendment generally exempts the same list of programs and activities as the House amendment exempts. Additionally, the Senate specifies that programs are identified by the designated account number in the Budget of the United States Government, 1986—Appendix.

Conference Agreement

The conference agreement generally follows the House amendment but veterans' compensation and veterans' pensions are classified as general exemptions. It also identifies programs by the account number in the 1986 Budget Appendix as provided in the Senate amendment. In addition, the conference agreement exempts from sequester the base outlays for programs subject to reductions through the automatic spending increase provisions. Further, cur-

rent judges salaries and future increases are exempt from sequestration.

c. Medicare

House Amendment

The House amendment treats medicare as an automatic increase program, but only for increases in hospital payment rates and in the index that limits physician payment increases. Thus, these increases can be reduced to zero, but not below. Other medicare payments are not reduced by a sequestration order.

Senate Amendment

The Senate amendment treats all medicare covered services, except clinical laboratory services, as controllable expenditures subject to reduction by the full sequestration percentage, thus permitting reductions below the previous year's payment levels. Clinical laboratory services, for which there is a statutory payment increase index, are treated under the rules applicable to automatic increase programs.

Conference Agreement

The reductions in the Medicare program are achieved through reductions in payment amounts for covered services. No changes in co-insurance or deductible obligations are made, and covered services are unaffected under a sequestration order.

Under such an order, each payment amount made under the Medicare program would be reduced by a specified percentage, which would be 1 percent for Fiscal Year 1986 and 2 percent for each subsequent year in which there is sequestration. (The reduction percentages would be proportionally reduced in any year in which the excess deficit is small enough to permit a smaller reduction.)

In any year for which there is sequestration, the reduction would be made from whatever level of payment would otherwise be provided under Medicare law and regulations. If hospital prospective payments were scheduled to increase by 4 percent, then a 2 percent reduction (that is, payment of 98 percent of the normal payment amount) would permit some increase to remain. On the other hand, if no hospital prospective payment increase were scheduled pursuant to Medicare law, then the sequestration reduction would reduce payments below the previous year's rates.

Where Medicare payment is based on discrete events or services such as hospital discharges or physician services rendered, the reduction factor would apply to those events or units. Where payment to providers is based on costs incurred over a period of time for an aggregation of services, the reduction would technically be calculated for the provider's cost reporting period. However, interim payments made throughout the cost reporting period would be appropriately adjusted.

The reduction would take effect as of a specific date (normally October 1). Where this date is not the beginning of a provider's cost reporting year, the requisite reduction would be prorated evenly over the months of the two cost reporting years to which it is appli-

cable. For example, if a 2 percent reduction were applicable to 9 months of one cost reporting period and 3 months of another period, a 2 percent reduction would be applied to nine-twelfths of the provider's otherwise payable costs for the first cost reporting period and three-twelfths for the second cost reporting period.

Final determinations regarding sequestration may be made after the date sequestration is to begin. For example, the final determination is not required until October 15 regarding a sequestration that begins October 1. If payments made before the final determination differ from those allowed under the final order, the conferees expect that the Department of Health and Human Services will recover the overpayments or restore the underpayments.

The payment reductions made pursuant to a sequestration order would not affect the co-insurance and deductible amounts payable by Medicare beneficiaries. Thus, with respect to physicians' services furnished by a participating physician, or for which an assignment is agreed to, the beneficiary would continue to be liable only for 20 percent of the Medicare "reasonable charge" (plus any applicable deductible), even though the amount paid to the physician is reduced by 1 or 2 percent. There would be no change in the fixed deductible and co-insurance amounts that hospitals and skilled nursing facilities are permitted to charge beneficiaries, even though the Medicare payments to these providers are reduced.

Medicare law determines payment amounts for health maintenance organizations (HMOs) through an estimate of what Medicare payments for all Medicare covered services will be in the HMO's service area in the HMO's forthcoming contract period. In making that estimate, Medicare payments previously made in that service area are taken into account. Since HMO payments will be directly reduced under a sequestration order, it would be inappropriate to build into the estimating process that determines HMO payments the Medicare payment reductions in the HMO's service area that are the result of sequestration reductions that have been or will be made. To do so would lead to reductions in HMO payments in excess of the reductions intended under sequestration. Accordingly, the effects of past or future sequestration reductions must be ignored in calculating normal HMO payment amounts; these normal payment amounts would then be reduced by the appropriate sequestration percentages.

d. Community and Migrant Health Centers, Indian Health Services and Facilities, and Veterans' Medical Care

House Amendment

The House amendment provides that Indian Health Services and Facilities, and Veterans' Medical Care would be fully available for sequestration. The Community and Migrant Health Center programs are exempt from any sequestration order.

Senate Amendment

The Senate amendment provides that these programs are fully available for sequestration.

Conference Agreement

The Conference Agreement requires two changes to the GSL program to occur automatically under sequestration. One, the special statutory allowance factor for lenders will be reduced by 0.40 percentage points, but not below 3.00 percent, in the first year of the loan. Two, a student's origination fee will increase by 0.50 percentage points. In both cases, sequestration affects only loans made during the applicable fiscal year but *after* the order is issued and only in the *first* year of the loan.

g. Social Security Trust Funds

House Amendment

The House amendment exempts Social Security from sequestration and amends Section 710 of the Social Security Act to provide, beginning with fiscal years beginning after September 30, 1985, that the receipts and disbursements of the Federal Old-Age and Survivors Insurance Trust Fund, and the Federal Disability Insurance Trust Fund, and the taxes imposed on employers, employees, and the self-employed would not be included in the totals of the Federal budget, either as submitted by the President or as stated in the Congressional budget. The amendment further provides that the receipts and disbursements of these funds shall be exempt from any general budget limitation imposed by statute on expenditures and net lending or budget outlays of the Federal government. This provision would expire on October 1, 1992, when the provision of current law removing the social security trust funds from the Federal budget takes effect.

The House amendment also provides that no provision of law enacted after the date of enactment of this Act, other than an appropriation to the trust funds already authorized under the Social Security Act as in effect on the date of enactment of this Act, may provide for payments from the general Treasury into the trust funds, or from the trust funds into the Treasury.

Senate Amendment

The Senate amendment is identical to the House amendment.

Conference Agreement

The Conference Agreement leaves unchanged from the House and Senate amendments the budgetary treatment of the Social Security trust funds. The conferees note that Section 201 includes the receipts and disbursements of the trust funds in the Federal budget for Fiscal Year 1986 through 1991 only for the purpose of the deficit estimates required to determine whether the Federal deficit is within the maximum deficit amount targets required in the emergency balanced budget act.

h. Child Support Enforcement Program

House Amendment

The House amendment provides that outlays for the child support enforcement program are available for sequester only by re-

ducing the Federal matching rate for State administrative expenses.

Senate Amendment

Same as the House amendment except for technical differences.

Conference Agreement

Same as the House amendment except for technical differences.

i. Foster Care and Adoption Assistance Programs

House Amendment

The House amendment limits the amount available for sequester in the foster care and adoption assistance programs: (1) to increases in foster care maintenance payment rates or adoption assistance payment rates; and (2) only to the extent that the reduction can be made by reducing Federal matching payments by a uniform percentage.

Senate Amendment

The Senate amendment makes amounts for these programs fully available for sequester. The Senate also provides that States may not alter payment timetables for the programs so as to change the fiscal year against which expenditures for the programs are charged.

Conference Agreement

The Conference Agreement follows the House amendment and adds the Senate prohibition against altering the payment timetable.

j. Unemployment Programs

House Amendment

The House amendment provides that regular State unemployment benefits, the State share of extended unemployment benefits, benefits paid to former Federal employees and former members of the armed services, and loans and advances to the State and Federal unemployment accounts are not available for sequester. The Federal share of extended benefits and Federally paid benefits and administrative expenses are fully available for sequester.

Senate Amendment

The Senate amendment follows the House amendment, but provides that benefits paid to former Federal employees and former members of the armed services are fully available for sequester.

Conference Agreement

The Conference Agreement follows the House amendment. It also provides that States may, without penalty, reduce their share of Federal-State extended unemployment benefits if the Federal share of benefits is reduced by a sequester order.

k. Mine Worker Disability

House Amendment

The House amendment provides that increases in black lung benefits and special benefits for disabled coal miners be treated in the same manner as automatic spending increases.

Senate Amendment

The Senate amendment follows the House amendment with technical differences.

Conference Agreement

The Conference Agreement follows the House amendment.

1. Federal Administrative Expenses

House Amendment

The House amendment exempts from reduction a number of programs and activities (including Social Security and railroad retirement benefits, Federal credit guarantee and insurance programs, and certain low income programs) without reference to administrative expenses.

Senate Amendment

The Senate amendment exempts programs and activities including Social Security (except administrative expenses), Federal disability insurance (except administrative expenses), and Federal credit guarantee and insurance programs (exempting only those outlays resulting from prior legal obligations of the government).

Conference Agreement

The Conference Agreement provides that Federal administrative expenses incurred in connection with any program, activity, or account shall be subject to reduction under a sequester order. Any exemption, exception, limitation, or special rule is not intended to include these Federal administrative or operating expenses unless it does so by specific reference.

Under this provision, administrative or operating expenses of all the departments and agencies of the Federal government, including independent agencies, would be subject to reduction unless specifically exempted. This provision includes programs and agencies that are self-financing and that do not receive appropriations.

The term administrative or operating expenses is intended to include obligations for items such as personnel compensation, travel, transportation, communication, equipment, supplies, materials, and other services. It is not the intent of the conferees to include payments, loans, or other benefits resulting from prior legal obligations under the term administrative or operating expenses.

For purposes of this section, payments made by the Federal government to reimburse or match administrative costs incurred by State or local governments, such as the Federal matching payments for State AFDC and Medicaid administrative expenses, shall not be considered administrative expenses.

tion dealing with the congressional budget process). These super-majority requirements would be a permanent addition to the Budget Act.

(b) *Other Waivers and Suspensions in the Senate.*—The conference report provides for several other super-majority waivers to exist only during fiscal years 1986 through 1991. The following sections can only be waived by a three-fifths vote of Senators, duly chosen and sworn: section 301(i) (relating to a point of order against budget resolutions breaching a maximum deficit amount); section 302(f) (relating to a point of order against spending bills breaching committee allocations); section 304(b) (relating to a point of order against subsequent budget resolutions breaching maximum deficit amount); section 310(b) (relating a point of order against amendments to reconciliation bills which would increase the deficit); section 310(g) (relating to a point of order against reconciliation bills which include social security provisions); and section 311(a) (relating to a point of order against spending or revenue measures which would cause the aggregate spending and revenue levels in the budget resolution to be breached).

(c) *Rulemaking Powers.*—The House and Senate amendments included identical language providing that all provisions of this title, except those relating to the activities of the executive branch, are enacted by the Congress as an exercise of the rulemaking powers of the House and Senate and may be changed by either as it desires. The conference agreement includes identical language except that it applies to all provisions of this title excluding activities of the *judicial*, as well as executive branches.

The conference report adopts super-majority waiver requirements (three-fifths, present and voting) for the House in two sections: 301(i) (relating to a point of order against budget resolution conference reports or amendments in disagreement breaching a maximum deficit amount) and 304(b) (relating to a point of order against subsequent budget resolution conference reports or amendments in disagreement breaching a maximum deficit amount).

IX. OTHER MATTERS

a. Restoration of Trust Fund Investments

House Amendment

The House amendment provides for restoration to the OASDI and other government trust funds of the securities cancelled since August 30, 1985 because of the failure to extend the debt ceiling limit by that date. Under the amendment, both principal and interest rate of these securities would be restored, as well as any interest payments lost to the various trust funds because of the failure to invest securities after August, 1985.

Senate Amendment

The Senate amendment generally follows the House amendment.

Conference Agreement

The conference agreement revises the House and Senate amendments in order to complete the process begun in Public Law 99-

155, the temporary debt limit increase enacted on November 14, 1985, of restoring various trust and retirement funds administered by the Secretary of the Treasury to the position in which they would have been if a debt limit increase had been enacted before September 3, 1985. In addition, an amount would be transferred to the Federal Old Age and Survivors Insurance Trust Fund ("OASI") and the Federal Disability Insurance Trust Fund ("DI") to compensate those funds for current and prospective losses arising from premature redemption of some long term securities when the debt limit was reached in September and October, 1984.

Subsection (a) makes whole, for 1985 transactions, all funds affected except the Department of Defense Military Retirement Fund, which is dealt with in subsection (b).

Paragraph (1) provides for the immediate reissuance to the trust funds of obligations prematurely redeemed during September, 1985. (Obligations prematurely redeemed during October and November, 1985 were restored as of November 14, 1985, as provided in the temporary debt limit increase, P.L. 99-155.) Although the bill covers all major trust funds, only OASI and DI were affected by premature redemptions in September, 1985 and only those two funds will be affected by this subsection. The conferees expect that the Treasury and the Department of Health and Human Services will work together to determine which securities would not have been redeemed during September, using standard Treasury investment practices, had an increased debt limit been in place on August 1. Treasury should then issue to the trust funds securities with identical maturities and interest rates to those that would not have been redeemed. On November 14, Treasury invested the then-uninvested balances in all the trust funds in short term securities. The restored securities will be substituted, dollar for dollar of principal amount, for securities in the funds on the date of enactment. The restoration should result, to the maximum extent practicable, in the funds' portfolios replicating the portfolios they would have had if the debt limit increase had been enacted on August 1. Upon completion of the restoration process, there will no longer be any possibility of prospective interest losses to the trust funds from the premature redemptions during 1985.

Paragraph (2) provides a general fund appropriation to all the major trust and retirement funds (except the Department of Defense Military Retirement Funds, which is covered in subsection (b)) for interest lost as a result of various non-standard trust fund transactions between September 1, 1985 and the date of enactment of the conference report. The amount to be paid to each fund will equal the difference between the net interest the fund would have earned in the period from September 1, 1985 to the date of enactment if an increased debt limit had been enacted on August 1, 1985, and net interest actually earned during that period. (The net amounts are to take into account the required repayment by OASI and DI to the general fund of excess interest earned in all months except October, 1985 as a result of the normalized tax transfer procedure.) Thus, interest earned since November 14 on securities restored as of that date pursuant to the temporary debt limit will not be paid twice. The payment will be made on December 31, 1985, the date on which the interest lost would normally have been credited

to the accounts according to the standard semi-annual interest payment feature of Treasury obligations. The conferees intend that in determining the full extent of these losses, Treasury will consult with the appropriate program agencies.

With respect to the Civil Service Retirement and Disability Fund and the Federal Supplemental Medical Insurance Fund ("FSMI"), investments that were to be made on September 30 and on October 1 and November 1, respectively, were delayed, in some cases until November 14. These funds lost approximately \$77.5 million and \$17.2 million, respectively, from the delay. Civil Service, OASI, DI and the Railroad Retirement Account also suffered interest losses from the accelerated redemption in November that was necessary to assure the payment of benefits. The losses from this source were approximately \$9 million for OASI and DI, combined, \$404,000 for Civil Service, and \$160,000 for the Railroad Retirement Account. Finally, OASI, DI and FSMI suffered some interest losses when high interest securities were prematurely redeemed. The funds will be made whole for all these losses.

Paragraph (3) lists the funds affected by paragraphs (a)(1) and (a)(2): OASI, DI, FSMI, Civil Service, Railroad Retirement, and the Federal Hospital Insurance Trust Fund. The Treasury has assured the conferees that in fact the Federal Hospital Insurance Trust Fund was operated normally during this period and therefore did not suffer any non-investments, delayed investments, disinvestments, or accelerated or premature redemptions.

Subsection (b) concerned restoration of the Department of Defense Military Retirement Fund. This fund, unlike those dealt with in subsection (a), invests in market based special obligations. Therefore, because Treasury could not fully invest the fund's \$10.5 billion credit on October 1, the fund suffered losses when interest rates subsequently declined.

Paragraph (1) provides for the immediate issuance to the fund of the securities it would have purchased on October 1, 1985. The securities are to carry the interest rates, and are to be purchased at the price (including accrued interest) that would have prevailed on October 1. To avoid a double investment of the October 1 credit, upon issuance of the new obligations, Treasury will cancel all obligations purchased by the fund with the October 1 credit. This will eliminate all prospective interest losses to the fund due to the decline in interest rates after October 1.

Paragraph (2) is a general fund appropriation to the Military Retirement Fund to cover interest losses arising from delayed investments. The Secretary of the Treasury, in consultation with the Secretary of Defense, will determine the amount of interest the fund would have earned between October 1 and November 14 if the fund had been able to fully invest on October 1. The amount of interest the fund actually collected on November 15 (the semi-annual interest payment date applicable to this fund's investments) on its limited investments of the October 1 credit will then be subtracted from the normal earnings and the difference paid to the fund. The interest collected on November 15 was invested on November 15 in new market based special obligations, in accordance with standard instructions of the Secretary of Defense. These investments have in turn been earning interest since November 15.

Paragraph (3) provides that the amount paid over in accordance with paragraph (2) will be invested in market based special obligations designated by the Secretary of Defense. These securities will have an issue date of November 15, 1985, and will be issued at prices, including accrued interest, prevailing on November 15. Thus, the shortfall in earnings due to late investment will earn interest from November 15, as would have been the case under normal circumstances.

Subsection (c) compensates a large number of funds for losses incurred because of their inability to invest receipts after December 7 due to the expiration of the temporary debt limit increase. Approximately 130 funds are potentially affected, almost all with respect to very small amounts not invested. In the past, these funds have not received any compensation when investment was prevented by the debt limit. Since these funds invest in market-based special obligations of many maturities and invest and redeem on a daily basis, it is virtually impossible to determine exactly what each would have earned if investments had been made. However, since the vast bulk of the investment would have been overnight, the conferees have determined that it would be appropriate to provide for compensation based on interest that would have been earned had all uninvested balances of which Treasury was aware been invested overnight. The conferees understand that the overnight rate is based on the overnight repurchase transaction rate calculated by the Federal Reserve Bank of New York.

Subsection (d) makes the OASI and DI funds whole for past and prospective interest losses arising from premature redemptions of long-term obligations in September and October, 1984.

Paragraph (1) provides for a general fund appropriation of an amount necessary to eliminate prospective interest losses arising from the 1984 transactions and requires the Secretary of the Treasury immediately to pay over this amount.

Paragraph (2) states that the amount to be paid over is to be determined jointly by the Secretary of the Treasury and the Secretary of Health and Human Services and is to "fully compensate" the funds. The conferees understand that the two agencies have already discussed the calculation and intend to make it as follows. First, the interest that would have been earned on the prematurely redeemed securities on each interest payment date will be determined. From this will be subtracted, on a payment-date-by-payment-date basis, interest that has been and will be earned by the funds on investments made to replace the prematurely redeemed securities. The present value of this stream of payments (including presumed reinvestment of interest earned) will be determined using a discount rate of 9½%, which is the statutory investment rate determined according to the formula in section 201(d) of the Social Security Act for June, 1986, as projected in the President's Budget for fiscal year 1986. This section is based on the current law practice under which, in June of each year, all maturing securities are replaced with long-term securities of various maturities, all bearing the June statutory investment rate. The conferees intend that the payment made pursuant to paragraph (1) will be treated, as any other payment made to the funds. Thus, it will be invested immediately in short term securities maturing on June 30,

1986. To the extent these securities are not redeemed prior to that time to pay benefits, they will become part of the pool of securities reinvested in long term securities on June 30, 1986.

Paragraph (3) places a limitation on transfers under paragraph (1) of \$550,000,000. This amount is in excess of all tentative calculations of the amount due under paragraph (1) made to date by the Secretaries of the Treasury and of Health and Human Services.

Paragraph (4) provides for adjustments in the payment after June, 1986 if the statutory interest rate for that month is other than 9 $\frac{7}{8}$ %. As soon as practicable after June 30, 1986, the Secretaries of the Treasury and Health and Human Services will determine whether any adjustment is necessary. In the event that the applicable interest rate is below 9 $\frac{7}{8}$ %, further payments will be due the fund, and an additional appropriation is provided for such adjustment. In the event that the applicable interest rate is above 9 $\frac{7}{8}$ %, the adjustment will require that the funds repay to the general fund part or all of (but not more than) the amount transferred under paragraph (1).

SECTION 275

(a) Effective Dates.

Except as described below, the provisions of this Act are to become effective upon enactment, and shall apply with respect to fiscal year 1986 and beyond.

Certain provisions of this Act will not apply until the fiscal year 1987 congressional budget cycle. An effective date of April 15, 1986 has been specified for these provisions. This is the date by which Congress must complete action on the budget resolution for fiscal year 1987. These provisions are:

(1) Section 201(a)(2) of this Act, which expand the definition of "budget authority" to include the authority to collect offsetting receipts.

(2) Section 201(b) insofar as it relates to the following sections of the Budget Act: (A) section 302(c), providing a point of order against the consideration of a committee's legislation until that committee has filed its suballocations pursuant to section 302(b)

(3) Section 212 of this Act, which provides a point of order against the consideration of legislation providing new audit authority unless that authority is limited to amount provided—appropriation Acts.

(b) Expired.

Except as described below, the provisions of this Act are permanent.

The following provisions will expire on September 30, 1991 (the end of fiscal year 1991):

(1) Part C of this Act, containing the emergency deficit control procedures.

(2) Section 3(f) of the Budget Act, specifying the maximum deficit amounts for fiscal year 1986 through 1991.

(3) Sections 301(i) and 304(b) of the Congressional Budget Act, providing points of order against budget resolutions with deficits in excess of the maximum deficit level.

(4) The provision of section 311(a) of the Congressional Budget Act which enforces the maximum deficit level in the Senate.

(5) Sections 1105(f) and 1106(c) of Title 31, United States Code, which require that the President's budget submission and any revisions be consistent with the maximum deficit levels.

(6) Section 271(b) which requires a vote of three-fifths of the members duly chosen and sworn in the Senate at points of order enforcing the maximum deficit level, section 302(b) suballocations, requiring deficit neutral amendments to reconciliation legislation, prohibiting Social Security provisions in a reconciliation bill (or a bill considered pursuant to reconciliation procedures), and the total budget ceilings and revenue flow.

(7) Section 302(f), providing points of order against legislation in the House which exceeds section 302(a) allocations, and in the Senate which exceeds section 302(b) suballocations.

(8) Section 302(g), providing that the Budget Committees are responsible for determining levels for the purposes of section 302.

(9) Section 310(c), providing for some flexibility in the response to reconciliation instructions for those committees which are instructed to both decrease spending and increase revenues.

(10) Section 310(d), providing a point of order against amendments to reconciliation bills which are not deficit neutral.

(11) Section 310(g), providing a point of order against a reconciliation bill which recommends changes in Social Security.

From the Committee on Ways and Means:

DAN ROSTENKOWSKI,
SAM M. GIBBONS,
J.J. PICKLE,
CHARLES B. RANGEL,
PETE STARK,
JAMES JONES,
ED JENKINS,
RICHARD A. GEPHARDT,
MARTY RUSSO,
JOHN J. DUNCAN,
BILL ARCHER,
GUY VANDER JAGT,
BILL FRENZEL,

From the Committee on Appropriations:

JAMIE L. WHITTEN,
EDWARD P. BOLAND,
WILLIAM H. NATCHER,
NEAL SMITH,
CARL PURSELL,
TOM LOEFFLER,

From the Committee on Rules:

CLAUDE PEPPER,
ANTHONY C. BEILENSON,
MARTIN FROST,

From the Committee on Government Operations:

DON FUQUA,
THOMAS N. KINDNESS,

From the Committee on the Budget:

GEO. MILLER,
MARVIN LEATH,
WILLIS GRADISON,

As additional conferees:

THOMAS S. FOLEY,
LES ASPIN,
MARY ROSE OAKAR,
LEON PANETTA,
VIC FAZIO,
ROBERT H. MICHEL,
DICK CHENEY,
LYNN MARTIN,
CONNIE MACK,

Managers on the Part of the House.

BOB PACKWOOD,
PETE V. DOMENICI,
JOHN C. DANFORTH,
W.L. ARMSTRONG,
PHIL GRAMM,
WARREN B. RUDMAN,
RUSSELL B. LONG,
LLOYD BENTSEN,
J. BENNETT JOHNSTON,
CARL LEVIN,
DAVID L. BOREN,
ERNEST F. HOLLINGS,

Managers on the Part of the Senate.



Finder's Aid
P.L. 99-190 (99 Stat. 1185) Approved December 19, 1985
Continuing Appropriations for Fiscal Year 1986

<u>Subject</u>	<u>S.S. Act</u> <u>Section</u>	<u>P.L.</u> <u>Section</u>	<u>99</u> <u>Stat.</u>	<u>H.Rep.</u> <u>99-403</u>	<u>S.Rep.</u> <u>99-210</u>	<u>H.C.Rep.</u> <u>99-443</u>
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Note: There are no amendments to the Social Security Act contained in this Public Law. The provisions included here deal with appropriations for programs administered under the Social Security Act.



*Public Law 99-190
99th Congress

Joint Resolution

Making further continuing appropriations for the fiscal year 1986, and for other purposes.

Dec. 19, 1985
[H.J. Res. 465]

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are hereby appropriated, out of any money in the Treasury not otherwise appropriated, and out of applicable corporate or other revenues, receipts, and funds, for the several departments, agencies, corporations, and other organizational units of the Government for the fiscal year 1986, and for other purposes, namely:

SEC. 101. (a) Such amounts as may be necessary for programs, projects, or activities provided for in the Agriculture, Rural Development, and Related Agencies Appropriations Act, 1986 (H.R. 3037), to the extent and in the manner provided for in the conference report and joint explanatory statement of the Committee of Conference (House Report Numbered 99-439), as filed in the House of Representatives on December 12, 1985, as if such Act had been enacted into law.

Notwithstanding any other provision of this Joint Resolution, each appropriation item in the referenced bill (H.R. 3037) made available under this subsection may be reduced by six-tenths of 1 per centum, if applied to every appropriation item, rounded to the nearest thousands of dollars, except for the following appropriations: Child Nutrition Programs and Special Milk Program which are true entitlements: *Provided*, That such reductions, if made, shall be applied proportionally to each program, project, and activity as set forth in the conference agreement (H. Rept. 99-439).

(b) such amounts as may be necessary for programs, projects or activities provided for in the Department of Defense Appropriations Act, 1986, at a rate of operations and to the extent and in the manner provided as follows, to be effective as if it had been enacted into law as the regular appropriation Act:

Infra.

AN ACT

Making appropriations for the Department of Defense for the fiscal year ending September 30, 1986, and for other purposes.

Department of
Defense
Appropriations
Act, 1986.

TITLE I

MILITARY PERSONNEL

MILITARY PERSONNEL, ARMY

For pay, allowances, individual clothing, subsistence, interest on deposits, gratuities, permanent change of station travel (including

*Note: The printed text of Public Law 99-190 is a reprint of the hand enrollment, signed by the President on December 19, 1985.

Speaker of the House of Representatives and the President of the Senate of a full and comprehensive report on such project, including the facts and circumstances relied upon in support of the proposed project.

The Secretary of Energy may transfer to the Emergency Preparedness appropriation such funds as are necessary to meet any unforeseen emergency needs from any funds available to the Department of Energy from this Act.

The reporting requirement established by the last paragraph under the heading "Department of Energy Alternative Fuels Production" in an Act making appropriations for the Department of the Interior and Related Agencies for the fiscal year ending September 30, 1980 (42 U.S.C. 5915 note; Public Law 96-126), is hereby repealed.

Repeal.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES AND SERVICES ADMINISTRATION

INDIAN HEALTH SERVICES

For expenses necessary to carry out the Act of August 5, 1954 (68 Stat. 674), the Indian Self-Determination Act, the Indian Health Care Improvement Act, and titles III and V and section 338G of the Public Health Service Act with respect to the Indian Health Service, including hire of passenger motor vehicles and aircraft; purchase of reprints; purchase and erection of portable buildings; payments for telephone service in private residences in the field, when authorized under regulations approved by the Secretary, \$823,133,000: *Provided*, That funds made available to tribes and tribal organizations through grants and contracts authorized by the Indian Self-Determination and Education Assistance Act of 1975 (88 Stat. 2203; 25 U.S.C. 450), shall remain available until September 30, 1987. Funds provided in this Act may be used for one-year contracts and grants which are to be performed in two fiscal years, so long as the total obligation is recorded in the year for which the funds are appropriated: *Provided further*, That the amounts collected by the Secretary of Health and Human Services under the authority of title IV of the Indian Health Care Improvement Act shall be available until September 30, 1987, for the purpose of achieving compliance with the applicable conditions and requirements of titles XVIII and XIX of the Social Security Act (exclusive of planning, design, construction of new facilities, or major renovation of existing Indian Health Service facilities): *Provided further*, That funding contained herein, and in any earlier appropriations Acts, for scholarship programs under section 103 of the Indian Health Care Improvement Act and section 338G of the Public Health Service Act with respect to the Indian Health Service shall remain available for expenditure until September 30, 1987.

42 USC
2001-2004 b.
25 USC 450 note.
25 USC 1601
note.
42 USC 241, 219,
254r.

25 USC note
prec. 1651.

42 USC 1395,
1396.

25 USC 1613.
42 USC 254r.

INDIAN HEALTH FACILITIES

For construction, major repair, improvement, and equipment of health and related auxiliary facilities, including quarters for personnel; preparation of plans, specifications, and drawings; acquisition of sites, purchase and erection of portable buildings, purchases of trailers and for provision of domestic and community sanitation

column number 2 of the Tariff Schedules of the United States, and 19 USC 1202.

(2) to deny credit, credit guarantees, and investment guarantees to, or for the benefit of, Afghanistan under any Federal program.

(b) If the President has not denied nondiscriminatory trade treatment to the products of Afghanistan before the date that is 45 days after the date of enactment of this joint resolution, the President shall submit to the Congress on such date.

This subsection may be cited as the "Foreign Assistance and Related Programs Appropriations Act, 1986".

(j) Such amounts as may be necessary for continuing the following activities, not otherwise provided for in this joint resolution, which were conducted in the fiscal year 1985, under the terms and conditions provided in applicable appropriations Acts for the fiscal year 1985, at the current rate: *Provided*, That no appropriation or fund made available or authority granted pursuant to this subsection shall be used to initiate or resume any project or activity for which appropriations, funds, or authority were not available during fiscal year 1985:

Foreign Assistance and Related Programs Appropriations Act, 1986.

Activities under sections 236, 237, and 238 of the Trade Act of 1974;

19 USC 2296-2298.

Activities under the Public Health Service Act;

42 USC 201 note. 8 USC 1106.

Refugee and entrant assistance activities under the provisions of title IV of the Immigration and Nationality Act including \$50,000,000 for targeted assistance grants and \$4,000,000 for voluntary agency matching grants; title IV and part B of title III of the Refugee Act of 1980; and sections 501 (a) and (b) of the Refugee Education Assistance Act of 1980;

8 USC 1521, 1525.

Foster care and adoption assistance activities under title IV-E of the Social Security Act under the terms and conditions established by sections 474(b) and 474(c) of that Act, and sections 102(a)(1) and 102(c) of Public Law 96-272: *Provided*, That, for the purpose of giving effect to this paragraph, references in such sections to fiscal year 1985 are deemed to be references to fiscal year 1986; and

8 USC 1522 note. 42 USC 670. 42 USC 674. 42 USC 672 note.

Minority science improvement activities under section 528(3) of the Omnibus Budget Reconciliation Act of 1981.

20 USC 3489.

SEC. 102. Unless otherwise provided for in this joint resolution or in the applicable appropriations Act, appropriations and funds made available and authority granted pursuant to this joint resolution shall be available from December 13, 1985, and shall remain available until (a) enactment into law of an appropriation for any project or activity provided for in this joint resolution, or (b) enactment of the applicable appropriations Act by both Houses without any provision for such project or activity, or (c) September 30, 1986, whichever first occurs.

SEC. 103. Appropriations made and authority granted pursuant to this joint resolution shall cover all obligations or expenditures incurred for any program, project, or activity during the period for which funds or authority for such project or activity are available under this joint resolution.

SEC. 104. Expenditures made pursuant to this joint resolution shall be charged to the applicable appropriation, fund, or authorization whenever a bill in which such applicable appropriation, fund, or authorization is contained is enacted into law.

of this joint resolution. The Administrator shall, within available resources, provide additional funds and personnel ceilings to each hospital director with a delegated project for necessary and adequate engineering, contracting, and other technical support. The delegation of authority for actual construction of said facilities shall be at the discretion of the selected hospital directors.

Prohibitions.
Courts, U.S.
California.

SEC. 122. None of the funds made available by this or any other Act for fiscal year 1986 to the Office of the Secretary, Department of the Interior, shall be expended to submit to the United States District Court for Eastern California any settlement with respect to Westlands Water District v. United States, et al., (CV-F-81-245-EDP) until: (1) April 15, 1986, and (2) until the Congress has received from the Secretary and reviewed for a period of 30 days a copy of the proposed settlement agreement which has been approved and signed by the Secretary.

Animals.
Illinois.

SEC. 123. Appropriations and funds available to the United States Fish and Wildlife Service shall be available for, and the Secretary of the Interior shall immediately resume preparation of, all environmental assessments and statements that are necessary prerequisites to the translocation of a portion of the existing population of Southern sea otters (*Enhydra lutris nereis*) to one or more locations within their historic range in accordance with the recovery plan for such species. In preparing such assessments and statements the Secretary shall consider section 10(j) of the Endangered Species Act (16 U.S.C. 1539(j)) as well as pending legislation that would amend such Act: *Provided*, That the Secretary of the Army is directed to accomplish emergency bank stabilization, shore protection, and flood control work to protect public-owned property in the vicinity of Jarvis Avenue, Fargo Avenue, North Shore Avenue, Rosemont Avenue, Burger Park, North Sheridan Road, and Lake Michigan in Chicago, Illinois, at full Federal expense using funds heretofore and hereafter appropriated at an estimated cost of \$1,000,000.

42 USC 3001-1,
3001-4, 300m.

Grants.

Ante, p. 1102.
42 USC 3001-5.

42 USC 3001-5
note.

8 USC 1524 note.
Insurance.
42 USC 294a.

42 USC 294.
Maryland.
Ohio.
Wisconsin.
California.

SEC. 124. No penalty shall be applied nor any State or agency agreement terminated pursuant to sections 1512, 1515, or 1521 of the Public Health Service Act during fiscal year 1986, nor if appropriations under title XV of that Act are reauthorized by August 15, 1986, shall any agency be required to take action to anticipate termination of financial assistance under that title. Sums appropriated by the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Act, 1986, for the award of grants under section 1516 of the Public Health Service Act may be used for grants under that section to State agencies that were authorized to receive grants for fiscal year 1982 under section 935(b) of the Omnibus Budget Reconciliation Act of 1981: *Provided*, That no sums may be obligated under the authority of this sentence after the date upon which a law is enacted to extend the authority to appropriate amounts to carry out title XV of such Act.

SEC. 125. The total principal amount of Federal loan insurance available under section 728 of the Public Health Service Act during fiscal year 1986 shall be granted by the Secretary of Health and Human Services without regard to any apportionment or other similar limitation, unless such apportionment or limitation is explicitly established, after the enactment of this joint resolution, as an amendment to subpart I of title VII-C of that Act.

SEC. 126. Notwithstanding any other provision of this joint resolution, the Secretary of Health and Human Services shall extend, for one additional year, approval to the municipal health services dem-

onstration projects located in Baltimore, Cincinnati, Milwaukee, and San Jose authorized under section 402(a) of the Social Security Amendments of 1967.

42 USC 1395b-1.

SEC. 127. From the amounts awarded to a State from its allotment under section 2003 of the Social Security Act for fiscal year 1986, the State shall use to maintain and improve the availability and quality of training provided under section 401(b)(1), 98 Stat. 2196, such sums as the State may determine to be required.

42 USC 1397b.

SEC. 128. Upon the enactment of the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Act, 1986, the amount provided therein for the Secretary of Education's discretionary fund for programs of national significance (for sums appropriated for carrying out title II of the Education for Economic Security Act) shall immediately become available for obligation.

Ante, p. 1102.

98 Stat. 1273.

SEC. 129. Notwithstanding any other provisions of this joint resolution or any other provision of law, any student residing in an area designated as a natural disaster area pursuant to a provision of Federal law may apply or reapply for a Pell Grant under subpart 1 of part A of title IV of the Higher Education Act of 1965 and be eligible for and receive a Pell award based on income earned in calendar year 1985 instead of 1984 if individuals whose incomes are taken into account in determining the student's eligibility for and amounts of a Pell Grant have been unable to pursue normal income-producing activities in 1985 as a result of the natural disaster.

Education.
20 USC 1070a
note.

20 USC 1070.

SEC. 130. (a) In the administration of subchapter III of chapter 83 of title 5, United States Code, title II of the Social Security Act, chapter 21 of the Internal Revenue Code of 1954, and title II of Public Law 98-168, the individual holding the position of Chief of the United States Capitol Police on January 1, 1985—

5 USC 8331 *et seq.*; 42 USC 401.
26 USC 3101 *et seq.*
5 USC 8331 note.

(1) shall be held and considered to have been appointed to that position before January 1, 1984,

(2) during the 60-day period following the date of the enactment into law of this section, shall be eligible to elect coverage under the provisions of such subchapter III, and

(3) upon such election, shall not be covered by section 210(a)(5)(G) of the Social Security Act, and section 3121(b)(5)(G) of the Internal Revenue Code of 1954, with respect to periods of service performed by such individual in such position after the election.

42 USC 410.
98 Stat. 1125.
26 USC 3121.

(b) Any period of service performed by such individual as Chief of the United States Capitol Police prior to making any such election shall, after such election and payment by or on behalf of such individual of appropriate contributions and interest covering such period of service, be considered as creditable service for purposes of such subchapter III and shall not be considered as covered service for purposes of title II of Public Law 98-168.

5 USC 8331 note.

(c) Service performed by such individual as Chief of the United States Capitol Police after December 31, 1983, and prior to the election referred to in subsection (a), shall also be considered "employment" for purposes of the provisions of title II of the Social Security Act and chapter 21 of the Internal Revenue Code of 1954, if such service would have been "employment" under such provisions but for this section.

42 USC 401; 26
USC 3101 *et seq.*

SEC. 131. Notwithstanding any other provision of law, the cost involved in providing basic training for members of the Capitol Police at the Federal Law Enforcement Training Center for fiscal

(C) The Subcommittee on the Panama Canal and Outer Continental Shelf of the Committee on Merchant Marine and Fisheries of the House of Representatives.

(D) The Subcommittee of the Interior of the Committee on Appropriations of the Senate.

(E) The Committee on Energy and Natural Resources of the Senate.

(2) Two United States Senators from California.

(3) Seven members of the California delegation to the House of Representatives.

Approved December 19, 1985.

LEGISLATIVE HISTORY—H.J. Res. 465:

HOUSE REPORTS: No. 99-403 (Comm. on Appropriation), No. 99-443 (Comm. of Conference) and No. 99-450 (Comm. of Conference).

SENATE REPORT No. 99-210 (Comm. on Appropriations).

CONGRESSIONAL RECORD, Vol. 131 (1985):

Dec. 4, considered and passed House.

Dec. 6, 9, 10, considered and passed Senate, amended.

Dec. 19, House and Senate agreed to conference report.

FURTHER CONTINUING APPROPRIATIONS, 1986

NOVEMBER 21, 1985.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. WHITTEN, by direction of the Committee on Appropriations,
submitted the following

R E P O R T

[To accompany H.J. Res. 465]

The accompanying joint resolution provides financing for the balance of fiscal year 1986 for programs funded by appropriation bills upon which action will not have been completed by December 12, 1985. The resolution applies until September 30, 1986, or until the regular annual appropriation bills are signed into law, whichever occurs first.

STATUS OF APPROPRIATION BILLS

The Committee on Appropriations reported the final regular appropriations bill on October 24 and twelve bills have passed the House. Floor action on the Foreign Assistance bill has not yet been scheduled.

As of November 21, the Senate had passed 10 bills and expects to complete action on the remaining 3 bills by December 12. Although conference action has been completed on four bills and two bills have been signed into law, it is apparent that congressional action on all bills will not be completed by December 12.

Therefore, timely enactment of the accompanying joint resolution is necessary to provide for the operation of numerous essential government programs.

The Committee emphasizes that the appropriation bills that have already been reported are within the totals set forth in the original House passed budget resolution and the adopted conference report on the budget resolution. The accompanying continuing resolution is also within the guidelines of the conference report on the Congressional budget resolution for fiscal year 1986.

LEVELS OF FUNDING UNDER THE RESOLUTION

Sections 101 (a-f) provide that for appropriation bills which have passed the House as of December 12, the funding level is the House passed bill. These bills include the following:

Agriculture, Rural Development, and Related Agencies Appropriations Act, 1986;

Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act, 1986;

Department of Defense Appropriations Act, 1986;

District of Columbia Appropriations Act, 1986;

Department of the Interior and Related Agencies Appropriations Act, 1986;

Department of Transportation and Related Agencies Appropriations Act, 1986.

For the Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1986, Section 101(g) provides the funding level of the conference report filed in the House.

For the Military Construction Appropriations Act, 1986 Section 101(h) provides the funding level of the House passed conference report (H. Rept. 99-380).

For the Treasury, Postal Service, and General Government Appropriations Act, 1986 Section 101(i) provides the funding level of the House passed conference report (H. Rept. 99-349).

For the Foreign Assistance and Related Programs Appropriations Act, 1986, Section 101(j) provides funding primarily at the levels provided for in H.R. 3228 as reported to the House. The Committee has included adjustments to H.R. 3228 that have become necessary because the authorizing legislation was signed into law after H.R. 3228 was reported. Titles I, II, and III of H.R. 2253 as reported on May 15, 1985 and section 3 of H.R. 1948 as introduced on April 3, 1985 are also included. Funds for Migration and Refugee Assistance are provided at the Administration request level.

Section 101(k) continues several programs at the 1985 level. The joint resolution provides for the continuation of the existing provisions of law regarding the prohibition of federally funded abortions and the prohibition against preventing the implementation of programs of voluntary school prayer and meditation in the public schools.

The Committee continues to be dedicated to the principle of financing federal programs under the traditional authorization and appropriations process which includes individual appropriation bills. Therefore, it will continue its efforts to get regular bills enacted as soon as possible.

The Committee emphasizes that when regular bills are signed into law, the provisions of the continuing resolution automatically disengage and the regular appropriation bills then become the funding device. This continuing resolution in no way precludes subsequent enactment into law of the regular appropriation bills.

OTHER TECHNICAL PROVISIONS OF THE RESOLUTION

The accompanying joint resolution carries the usual necessary technical provisions relating to obligations or expenditures made during the duration of the continuing resolution.

FURTHER CONTINUING APPROPRIATIONS, 1986

DECEMBER 6 (legislative day, DECEMBER 2), 1985.—Ordered to be printed

Mr. HATFIELD, from the Committee on Appropriations,
submitted the following

REPORT

[To accompany H.J. Res. 465]

The Committee on Appropriations, to which was referred the joint resolution (H.J. Res. 465) making further continuing appropriations for fiscal year 1986, and for other purposes, reports the same to the Senate with various amendments and presents herewith information relative to the recommended joint resolution.

INTRODUCTION

The Committee on Appropriations reported the last of the 13 regular fiscal year 1986 appropriations bills on November 6, 1985. To date, 3 of the 13 regular bills have been enacted into law: Energy-Water Development (Public Law 99-141), Legislative Branch (Public Law 99-151), and HUD-Independent Agencies (Public Law 99-160). Conference action has been completed on five other bills: Treasury-Postal Service, Military Construction, Labor-HHS-Education, Commerce-Justice-State, and the District of Columbia.

Of the remaining five regular fiscal year 1986 appropriations bills, the Senate has passed two bills (Agriculture and Transportation) and has begun consideration of the Interior bill. The Senate has not acted on either the Foreign Assistance or Defense bills. The House of Representatives has passed all these bills, with the exception of the Foreign Assistance bill.

Funding for programs and activities covered by the 10 fiscal year 1986 regular appropriations bills not yet enacted into law is currently provided under a temporary continuing resolution (Public Law 99-154).

DISTRICT OF COLUMBIA

Section 101(d) deletes House language establishing the rate of operations as that provided in the regular fiscal year 1986 appropriations bill (H.R. 3067) as passed by the House, and instead inserts the rate provided in the bill as passed by the Senate on November 7, 1985.

INTERIOR AND RELATED AGENCIES

Section 101(e) deletes House language establishing the rate of operations as that provided in the regular fiscal year 1986 appropriations bill (H.R. 3011) as passed by the House, and instead inserts the rate provided in the bill as reported to the Senate on September 24, 1985.

TRANSPORTATION AND RELATED AGENCIES

Section 101(f) deletes House language establishing the rate of operations as that provided in the regular fiscal year 1986 appropriations bill (H.R. 3244) as passed by the House, and instead inserts the rate provided in the bill as passed by the Senate on October 23, 1985 with two exceptions. Coast Guard operating expenses is funded at \$1,752,000,000 including transfers. This level, augmented by funding made available in Public Law 99-88, the fiscal year 1985 supplemental, and Public Law 99-145, the Department of Defense Authorization Act, 1986, is necessary to continue ongoing Coast Guard activities. In addition, the rate for Federal Aviation Administration operations is \$2,714,400,000, the amount originally adopted by the Subcommittee on Transportation.

LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES

Section 101(g) retains House language establishing the rate of operations as that provided in the conference agreement on the regular fiscal year 1986 appropriations bill (H.R. 3424), but includes an amendment to reference changes adopted by the House on December 5, 1985.

MILITARY CONSTRUCTION

Section 101(h) retains House language establishing the rate of operations as that provided in the conference agreement on the regular fiscal year 1986 appropriations bill (H.R. 3327).

TREASURY, POSTAL SERVICE, AND GENERAL GOVERNMENT

Section 101(i) retains House language establishing the rate of operations as that provided in the conference agreement on the regular fiscal year 1986 appropriations bill (H.R. 3036) with the deletion of amendment 83 dealing with Office of Personnel Management regulations, and recommends a further proviso reducing appropriations provided for both the Internal Revenue Service and the Postal Service revenue forgone subsidy.

SMITHSONIAN INSTITUTION

The Committee recommends a new section 140 adding language to the Senate-reported Interior appropriation bill allowing the use of funds available to the Smithsonian Institution to be used to support American overseas research centers.

MINERAL LANDS LEASING ACT

The Committee has included as a new section 141 bill language which delays the effective date of the provisions of section 2(a)(2)(A) of the Mineral Lands Leasing Act by almost 5 months. Under those provisions, coal companies are required to have begun coal production activities on certain federally leased tracts by August 4, 1986, in order to be eligible to receive any new lease for any mineral under the Mineral Leasing Act. Primarily because of exceptionally poor coal markets, many companies have been unable to meet this provision of law. The authorizing committees of Congress are now addressing legislation to remedy this situation. The Committee's language merely provides an additional period of nearly 5 months so that Congress is assured of adequate time to complete action prior to adjournment of the second session of the 99th Congress.

OUTER CONTINENTAL SHELF LEASING

The Committee concurs with the House language in section 165 on the need to have continuing negotiations on the oil and gas development of the California Outer Continental Shelf, and seeks to have the appropriate range of advice provided by the Congress to the Secretary as he strives to seek consensus through negotiation. While the Committee does not expect that the negotiating process will attempt to impose binding conditions on either the Secretary or the Congress, the ongoing negotiation process must continue so that this longstanding dispute can be resolved in a positive manner.

LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH RESOURCES AND SERVICES ADMINISTRATION

DISADVANTAGED ASSISTANCE

The Committee has included \$500,000 to bring the program of educational assistance to individuals from disadvantaged backgrounds who are pursuing careers in the health professions to its fully authorized amount. The Committee is aware of the truly pressing health care needs of our Nation's minorities. In utilizing these funds the Committee urges the Department of Health and Human Services to give priority to proposals which would ensure that minority graduates will serve those who are truly underserved; for example, on Indian reservations, areas

with geographical concentrations of native Hawaiians, or in the inner-city.

HEALTH PLANNING

It is the intent of the Committee that funds appropriated for health planning activities for fiscal year 1986 be used to allow all agencies to operate at their full program level until September 30, 1986. This action is taken to ensure that all planning agencies can maintain normal operations during fiscal year 1986 while Congress completes consideration of health planning reauthorization. Therefore, the Committee would bar the initiation of action to close State or local agencies at the end of fiscal 1986, provided that the health planning reauthorization is enacted by July 1, 1986. If supplemental funds are needed at that time to pay the cost of closeout activities, the Department should request such funds. In addition, as provided for in the last several continuing resolutions, the Department is precluded from terminating health systems agencies for not meeting outdated, strict staffing level requirements that many agencies could not attain due to reduced funding.

HEALTH EDUCATION ASSISTANCE LOANS

In 1985, the Office of Management and Budget initiated a procedure of apportioning annual amounts authorized for the Health Education Assistance Loan [HEAL] Guarantee Program. The Committee considers this procedure to be an unnecessary interference with program implementation. Congress intends that the full amount of principal and carry-over to be guaranteed be available the entire year to both first-time and repeat borrowers.

HEALTH CARE FINANCING ADMINISTRATION

DEMONSTRATION PROJECTS

The Committee has adopted bill language to require the Secretary of Health and Human Services to extend for 3 additional years the four municipal health services demonstration projects now authorized under Medicare's demonstration authority. This provision is also included in the House and Senate versions of the Consolidated Omnibus Budget Reconciliation Act of 1985.

OFFICE OF HUMAN DEVELOPMENT SERVICES

CHILD CARE AND CHILD ABUSE PREVENTION TRAINING

The Committee has included \$25,000,000 for the continuation of a program to improve child care training and, specifically, child abuse prevention training. This effort began last year. Section 401 of the continuing resolution for fiscal year 1985 (Public Law 98-473) allocated \$25,000,000 to the States for child care and child abuse prevention training. The Committee recognizes that the problem of child abuse and inadequate training of child care providers continues to be an extremely

serious one. This allocation of funds will allow the States to target training programs to those individuals who care for the youngest and most vulnerable of our children. These individuals frequently have little or no formal training in the field of child care, and because of their extremely low salary levels, cannot afford to pay for such training themselves.

Bill language is also included which follows up on a provision incorporated into last year's continuing resolution pertaining to child care standards. In order to provide guidance and assistance to the States in utilizing funds allocated pursuant to title XX of the Social Security Act, section 401 of Public Law 98-473 required the Secretary of Health and Human Services to draft and distribute to the States for their consideration, a Model Child Care Standards Act containing minimum licensing or registration standards for day care centers, group homes, and family day care homes. That document was published by the Department of Health and Human Services in January 1985. In this resolution, recommended bill language provides that a State's allotment of the \$25,000,000 in additional title XX funds will not be made unless the State has certified to the Secretary of Health and Human Services that it has completed a process, or has instituted or plans to institute a process which it will complete within 6 months, to review its child-care licensing or registration and monitoring standards. States are expected to take into consideration the information and material contained in the Department of Health and Human Services' Model Child Care Standards Act, in order to identify and correct deficiencies in such licensing or registration and monitoring standards in terms of protecting the welfare of children in child-care settings. The Secretary of Health and Human Services is expected to report to the Committee on the certifications made pursuant to this provision before the fiscal 1987 Labor-HHS-Education Appropriations Subcommittee hearings on human development activities.

RURAL DEVELOPMENT LOAN FUND

The Committee is aware that for almost 18 months rural development loan fund intermediaries and officials from the Department of Health and Human Services have been negotiating a modification of the rural development loan fund [RDLF] interest rate structure. While a tentative agreement has been reached, final approval has been delayed. In the meantime, effective October 1, 1985, interest rates on many RDLF loans jumped to almost 10 percent. This increase will mean double-digit interest rates to RDLF borrowers, a situation incompatible with the intent of the RDLF Program.

Therefore, the Committee instructs the Department to complete negotiations with the intermediaries expeditiously. Until these negotiations are completed, the Committee directs the RDLF interest rates be maintained at the rate in effect prior to October 1, 1985.



MAKING FURTHER CONTINUING APPROPRIATIONS FOR FISCAL YEAR 1986, AND FOR OTHER PURPOSES

DECEMBER 16, 1985.—Ordered to be printed

Mr. WHITTEN, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.J. Res. 465]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.J. Res. 465) making further continuing appropriations for the fiscal year 1986, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its amendments numbered 3, 5, 11, 15, 16, 27, 28, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 52, 53, 54, 55, 59, 63, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 106, 116, 121, and 134.

That the House recede from its disagreement to the amendments of the Senate numbered 9, 12, 17, 18, 19, 20, 21, 25, 61, 118, 119, and 120, and agree to the same.

Amendment numbered 1:

That the House recede from its disagreement to the amendment of the Senate numbered 1, and agree to the same with an amendment, as follows:

In lieu of the matter stricken and inserted by said amendment insert the following:

(a) Such amounts as may be necessary for programs, projects, or activities provided for in the Agriculture, Rural Development, and Related Agencies Appropriations Act, 1986 (H.R. 3037), to the extent and in the manner provided for in the conference report and joint explanatory statement of the Committee of Conference (House Report Numbered 99-439), as filed in the House of Representatives on December 12, 1985, as if such Act had been enacted into law.

And the Senate agree to the same.

Amendment numbered 2:

That the House recede from its disagreement to the amendment of the Senate numbered 103, and agree to the same with an amendment, as follows:

In lieu of the first section number named in said amendment insert: 124 ; and the Senate agree to the same.

Amendment numbered 104:

That the House recede from its disagreement to the amendment of the Senate numbered 104, and agree to the same with an amendment, as follows:

In lieu of the matter proposed by said amendment insert:

SEC. 125. Notwithstanding any other provision of this joint resolution, the Secretary of Health and Human Services shall extend, for one additional year, approval of the municipal health services demonstration projects located in Baltimore, Cincinnati, Milwaukee, and San Jose authorized under section 402(a) of the Social Security Amendments of 1967.

And the Senate agree to the same.

Amendment numbered 105:

That the House recede from its disagreement to the amendment of the Senate numbered 105, and agree to the same with an amendment, as follows:

In lieu of the matter proposed by said amendment insert:

SEC. 126. From the amounts awarded to a State from its allotment under section 2003 of the Social Security Act for fiscal year 1986, the State shall use to maintain and improve the availability and quality of training provided under section 401(b)(1), 98 Stat. 2196, such sums as the State may determine to be required.

And the Senate agree to the same.

Amendment numbered 107:

That the House recede from its disagreement to the amendment of the Senate numbered 107, and agree to the same with an amendment, as follows:

In lieu of the section number named in said amendment insert: 127; and the Senate agree to the same.

Amendment numbered 108:

That the House recede from its disagreement to the amendment of the Senate numbered 108, and agree to the same with an amendment, as follows:

In lieu of the matter proposed by said amendment insert:

SEC. 128. Notwithstanding any other provisions of this joint resolution or any other provision of law, any student residing in an area designated as a natural disaster area pursuant to a provision of Federal law may apply or reapply for a Pell Grant under subpart 1 of part A of title IV of the Higher Education Act of 1965 and be eligible for and receive a Pell award based on income earned in calendar year 1985 instead of 1984 if individuals whose incomes are taken into account in determining the student's eligibility for and amount of a Pell Grant have been unable to pursue normal income-producing activities in 1985 as a result of the natural disaster.

And the Senate agree to the same.

Amendment numbered 109:

That the House recede from its disagreement to the amendment of the Senate numbered 109, and agree to the same with an amendment, as follows:

In lieu of the section number named in said amendment insert: 127; and the Senate agree to the same.

Amendment numbered 108:

That the House recede from its disagreement to the amendment of the Senate numbered 108, and agree to the same with an amendment, as follows:

In lieu of the matter proposed by said amendment insert:

SEC. 128. Notwithstanding any other provisions of this joint resolution or any other provision of law, any student residing in an area designated as a natural disaster area pursuant to a provision of Federal law may apply or reapply for a Pell Grant under subpart 1 of part A of title IV of the Higher Education Act of 1965 and be eligible for and receive a Pell award based on income earned in calendar year 1985 instead of 1984 if individuals whose incomes are taken into account in determining the student's eligibility for and amount of a Pell Grant have been unable to pursue normal income-producing activities in 1985 as a result of the natural disaster.

And the Senate agree to the same.

Amendment numbered 109:

That the House recede from its disagreement to the amendment of the Senate numberd 109, and agree to the same with an amendment, as follows:

In lieu of the matter sticken and inserted by said amendment, insert: 129; and the Senate agree to the same.

Amendment numbered 110:

That the House recede from its disagreement to the amendment of the Senate numberd 110, and agree to the same with an amendment, as follows:

In lieu of the section number named in said amendment, insert: 130; and the Senate agree to the same.

Amendment numbered 111:

That the House recede from its disagreement to the amendment of the Senate numbered 111, and agree to the same with an amendment, as follows:

In lieu of the matter proposed by said amendment, insert:

SEC. 131. Notwithstanding any other provision of this joint resolution, there is appropriated \$150,000 for fiscal year 1986 for the establishment and operation of the Biomedical Ethics Board and the Biomedical Ethics Advisory Committee pursuant to section 381 of the Public Health Service Act.

And the Senate agree to the same.

Amendment numbered 112:

That the House recede from its disagreement to the amendment of the Senate numbered 112, and agree to the same with an amendment, as follows:

In lieu of the first section number named in said amendment: insert: 132; and the Senate agree to the same.

Amendment numbered 113:

That the House recede from its disagreement to the amendment of the Senate numbered 113, and agree to the same with an amendment, as follows:

In lieu of the first section number named in said amendment, insert: 133; and the Senate agree to the same.

Amendment numbered 114:



In lieu of the matter stricken and inserted by said amendment, insert: 129; and the Senate agree to the same.

Amendment numbered 110:

That the House recede from its disagreement to the amendment of the Senate numbered 110, and agree to the same with an amendment, as follows:

In lieu of the section number named in said amendment, insert: 130; and the Senate agree to the same.

Amendment numbered 111:

That the House recede from its disagreement to the amendment of the Senate numbered 111, and agree to the same with an amendment, as follows:

In lieu of the matter proposed by said amendment, insert:

SEC. 131. Notwithstanding any other provision of this joint resolution, there is appropriated \$150,000 for fiscal year 1986 for the establishment and operation of the Biomedical Ethics Board and the Biomedical Ethics Advisory Committee pursuant to section 381 of the Public Health Service Act.

And the Senate agree to the same.

Amendment numbered 112:

That the House recede from its disagreement to the amendment of the Senate numbered 112, and agree to the same with an amendment, as follows:

In lieu of the first section number named in said amendment: insert: 132; and the Senate agree to the same.

Amendment numbered 113:

That the House recede from its disagreement to the amendment of the Senate numbered 113, and agree to the same with an amendment, as follows:

In lieu of the first section number named in said amendment, insert: 133; and the Senate agree to the same.

Amendment numbered 114:

That the House recede from its disagreement to the amendment of the Senate numbered 114, and agree to the same with an amendment, as follows:

In lieu of the first section number named in said amendment, insert: 134; and the Senate agree to the same.

Amendment numbered 115:

That the House recede from its disagreement to the amendment of the Senate numbered 115, and agree to the same with an amendment, as follows:

In lieu of the matter proposed by said amendment, insert the following:

SEC. 135. Notwithstanding any other provision of this joint resolution or any other Act, the Department of the Navy is authorized, within existing appropriations, to expend such sums as are necessary to effectuate a settlement with the State of Washington of back tax liabilities arising out of Federal construction and procurement projects in Washington State. Such settlement may be negotiated directly between the Department of the Navy and the State of Washington, notwithstanding the fact that the liability of the Department of the Navy may be derivative from persons contracting with the Department.

And the Senate agree to the same.



HOUSE JOINT RESOLUTION 465, FURTHER CONTINUING
APPROPRIATIONS FOR FISCAL YEAR 1986

DECEMBER 19, 1985.—Ordered to be printed

Mr. WHITTEN, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.J. Res. 465]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.J. Res. 465) making further continuing appropriations for the fiscal year 1986, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its amendments numbered 3, 5, 11, 15, 16, 27, 28, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 48, 52, 53, 54, 55, 59, 63, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 106, 116, 121, 122, and 134.

That the House recede from its disagreement to the amendments of the Senate numbered 9, 12, 17, 18, 19, 20, 21, 25, 61, 118, 119, and 120, and agree to the same.

Amendment numbered 1:

That the House recede from its disagreement to the amendment of the Senate numbered 1, and agree to the same with an amendment, as follows:

In lieu of the matter stricken and inserted by said amendment insert the following:

(a) Such amounts as may be necessary for programs, projects, or activities provided for in the Agriculture, Rural Development, and Related Agencies Appropriations Act, 1986 (H.R. 3037), to the extent and in the manner provided for in the conference report and joint explanatory statement of the Committee on Conference (House Report Numbered 99-439), as filed in the House of Representatives on December 12, 1985, as if such Act had been enacted into law.

That the House recede from its disagreement to the amendment of the Senate numbered 102, and agree to the same with an amendment, as follows:

In lieu of the matter proposed by said amendment insert:

SEC. 123. No penalty shall be applied nor any State or agency agreement terminated pursuant to sections 1512, 1515, or 1521 of the Public Health Service Act during fiscal year 1986, nor if appropriations under title XV of that Act are reauthorized by August 15, 1986, shall any agency be required to take action to anticipate termination of financial assistance under that title. Sums appropriated by the Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Act, 1986, for the award of grants under section 1516 of the Public Health Service Act may be used for grants under that section to State agencies that were authorized to receive grants for fiscal year 1982 under section 935(b) of the Omnibus Budget Reconciliation Act of 1981: Provided, That no sums may be obligated under the authority of this sentence after the date upon which a law is enacted to extend the authority to appropriate amounts to carry out title XV of such Act.

And the Senate agree to the same.

Amendment numbered 103:

That the House recede from its disagreement to the amendment of the Senate numbered 103, and agree to the same with an amendment, as follows:

In lieu of the first section number named in said amendment insert: *124*; and the Senate agree to the same.

Amendment numbered 104:

That the House recede from its disagreement to the amendment of the Senate numbered 104, and agree to the same with an amendment, as follows:

In lieu of the matter proposed by said amendment insert:

SEC. 125. Notwithstanding any other provision of this joint resolution, the Secretary of Health and Human Services shall extend, for one additional year, approval of the municipal health services demonstration projects located in Baltimore, Cincinnati, Milwaukee, and San Jose authorized under section 402(a) of the Social Security Amendments of 1967.

And the Senate agree to the same.

Amendment numbered 105:

That the House recede from its disagreement to the amendment of the Senate numbered 105, and agree to the same with an amendment, as follows:

In lieu of the matter proposed by said amendment insert:

SEC. 126. From the amounts awarded to a State from its allotment under section 2003 of the Social Security Act for fiscal year 1986, the State shall use to maintain and improve the availability and quality of training provided under section 401(b)(1), 98 Stat. 2196, such sums as the State may determine to be required.

And the Senate agree to the same.

Amendment numbered 107:

That the House recede from its disagreement to the amendment of the Senate numbered 107, and agree to the same with an amendment, as follows:

Finder's Aid
P.L. 99-198 (99 Stat. 1354) Approved December 23, 1986
Food Security Act of 1985

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>99 Stat.</u>	<u>H.Rep. 99-271 Part 1</u>	<u>H.Rep. 99-271 Part 2</u>	<u>S.Rep. 99-145</u>	<u>H.C.Rep. 99-447</u>
Unemployment Compensation - Definition Applicable to Disclosure of Information for Food Stamp Purposes	303(d)(2) New	1535(b)(3) (B)	1584	—	—	226, 448, 552, 553	241, 242, 545
Unemployment Compensation - Definition Applicable to Disclosure of Information for Food Stamp Purposes (technical amendment)	303(d)(2) Redesig- nated (d)(3)	1535(b)(3) (A)	1584	—	—	—	241
Unemployment Compensation - Definition Applicable to Disclosure of Information for Food Stamp Purposes (technical amendment)	303(d)(3) Redesig- nated (d)(4)	1535(b)(3) (A)	1584	—	—	—	241



PUBLIC LAW 99-198—DEC. 23, 1985

FOOD SECURITY ACT OF 1985

***Public Law 99-198**
99th Congress

An Act

Dec. 23, 1985

[H.R. 2100]

Food Security
 Act of 1985.
 Farms and
 farming.
 Agriculture and
 agricultural
 commodities.
 7 USC 1281 note.

To extend and revise agricultural price support and related programs, to provide for agricultural export, resource conservation, farm credit, and agricultural research and related programs, to continue food assistance to low-income persons, to ensure consumers an abundance of food and fiber at reasonable prices, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "Food Security Act of 1985".

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SEC. 2. The table of contents is as follows:

Sec. 1. Short title.

Sec. 2. Table of contents.

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Subtitle A—Milk Price Support and Producer-Supported Dairy Program

Sec. 101. Milk price support, price reduction, and milk production termination programs for calendar years 1986 through 1990.

Sec. 102. Administrative procedures.

Sec. 103. Application of support price for milk.

Sec. 104. Avoidance of adverse effect of milk production termination program on beef, pork, and lamb producers.

Sec. 105. Domestic casein industry.

Sec. 106. Study relating to casein.

Sec. 107. Circumvention of historical distribution of milk.

Sec. 108. Application of amendments.

Subtitle B—Dairy Research and Promotion

Sec. 121. National Dairy Research Endowment Institute.

Subtitle C—Milk Marketing Orders

Sec. 131. Minimum adjustments to prices for fluid milk under marketing orders.

Sec. 132. Adjustments for seasonal production; hearings on amendments; determination of milk prices.

Sec. 133. Marketwide service payments.

Sec. 134. Status of producer handlers.

Subtitle D—National Commission on Dairy Policy

Sec. 141. Findings and declaration of policy.

Sec. 142. Establishment of commission.

Sec. 143. Study and recommendations.

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Sec. 145. Financial support.

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Subtitle E—Miscellaneous

Sec. 151. Transfer of dairy products to the military and veterans hospitals.

Sec. 152. Extension of the dairy indemnity program.

Sec. 153. Dairy export incentive program.

*Note: The printed text of Public Law 99-198 is a reprint of the hand enrollment, signed by the President on December 23, 1985.

TITLE II—WOOL AND MOHAIR

- Sec. 201. Extension of price support program.
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TITLE III—WHEAT

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- Sec. 302. Marketing quotas.
- Sec. 303. Marketing quota apportionment factor.
- Sec. 304. Farm marketing quotas.
- Sec. 305. Marketing penalties.
- Sec. 306. Referendum.
- Sec. 307. Transfer of farm marketing quotas.
- Sec. 308. Loan rates, target prices, disaster payments, acreage limitation and set-aside programs, and land diversion for the 1986 through 1990 crops of wheat.
- Sec. 309. Nonapplicability of certificate requirements.
- Sec. 310. Suspension of land use, wheat marketing allocation, and producer certificate provisions.
- Sec. 311. Suspension of certain quota provisions.
- Sec. 312. Nonapplicability of section 107 of the Agricultural Act of 1949 to the 1986 through 1990 crops of wheat.

TITLE IV—FEED GRAINS

- Sec. 401. Loan rates, target prices, disaster payments, acreage limitation and set-aside programs, and land diversion for the 1986 through 1990 crops of feed grains.
- Sec. 402. Nonapplicability of section 105 of the agricultural act of 1949 to the 1986 through 1990 crops of feed grains.
- Sec. 403. Price support for corn silage.

TITLE V—COTTON

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- Sec. 505. Skiprow practices.
- Sec. 506. Preliminary allotments for 1991 crop of upland cotton.
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- Sec. 702. National poundage quota and farm poundage quota.
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- Sec. 704. Marketing penalties; disposition of additional peanuts.
- Sec. 705. Price support program.
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- Sec. 1404. Responsibilities of the Secretary of Agriculture.
- Sec. 1405. Joint Council on Food and Agricultural Sciences.
- Sec. 1406. National Agricultural Research and Extension Users Advisory Board.
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- Sec. 1409. Competitive, special, and facilities research grants.
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- Sec. 1413. Food and human nutrition research and extension program.
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- Sec. 1451. Findings.
- Sec. 1452. Human nutrition research.
- Sec. 1453. Dietary assessment and studies.

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- Sec. 1461. Definitions.
- Sec. 1462. Findings.
- Sec. 1463. Purposes.
- Sec. 1464. Information study.
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- Sec. 1467. Reports.
- Sec. 1468. Agreements.
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- Sec. 1771. Land conveyance to Irwin County, Georgia.
- Sec. 1772. National tree seed laboratory.
- Sec. 1773. Control of grasshoppers and mormon crickets on all Federal lands.
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TITLE XVIII—GENERAL EFFECTIVE DATE

- Sec. 1801. Effective Date.

TITLE I—DAIRY

Subtitle A—Milk Price Support and Producer-Supported Dairy Program

MILK PRICE SUPPORT, PRICE REDUCTION, AND MILK PRODUCTION TERMINATION PROGRAMS FOR CALENDAR YEARS 1986 THROUGH 1990

Ante, p. 818.

SEC. 101. (a) Section 201(d) of the Agricultural Act of 1949 (7 U.S.C. 1446(d)) is amended by striking out paragraphs (1) and (2) and inserting in lieu thereof the following:

“(1)(A) During the period beginning on January 1, 1986, and ending on December 31, 1990, the price of milk shall be supported as provided in this subsection.

“(B) During the period beginning on January 1, 1986, and ending on December 31, 1986, the price of milk shall be supported at a rate equal to \$11.60 per hundredweight for milk containing 3.67 percent milkfat.

“(C)(i) During the period beginning on January 1, 1987, and ending on September 30, 1987, the price of milk shall be supported at a rate equal to \$11.35 per hundredweight for milk containing 3.67 percent milkfat.

“(ii) Except as provided in subparagraph (D), during the period beginning on October 1, 1987, and ending on December 31, 1990, the price of milk shall be supported at a rate equal to \$11.10 per hundredweight for milk containing 3.67 percent milkfat.

7 USC 1427.

“(D)(i) Subject to clause (ii), if for any of the calendar years 1988, 1989, and 1990, the level of purchases of milk and the products of milk under this subsection (less sales under section 407 for unrestricted use), as estimated by the Secretary on January 1 of such calendar year, will exceed 5,000,000,000 pounds (milk equivalent), on January 1 of such calendar year, the Secretary shall reduce by 50 cents the rate of price support for milk as in effect on such date.

Prohibition.

“(ii) The rate of price support for milk may not be reduced under clause (i) unless—

“(I) the milk production termination program under paragraph (3) achieved a reduction in the production of milk by participants in the program of at least 12,000,000,000 pounds during the 18 months of the program; or

Contracts.

“(II) the Secretary submits to Congress a certification, including a statement of facts in support of the certification of the Secretary, that reasonable contract offers were extended by the Secretary under such program but such offers were not accepted by a sufficient number of producers making reasonable bids for contracts to achieve such a reduction in production.

“(E) If for any of the calendar years 1988, 1989, and 1990, the level of purchases of milk and the products of milk under this

period, as calculated under regulations issued by the Secretary. The disqualification period imposed under subsection (b) shall continue in effect as to the person or persons who sell or otherwise transfer ownership of the retail food store or wholesale food concern notwithstanding the imposition of a civil money penalty under this subsection.

“(2) At any time after a civil money penalty imposed under paragraph (1) has become final under the provisions of section 14(a), the Secretary may request the Attorney General to institute a civil action against the person or persons subject to the penalty in a district court of the United States for any district in which such person or persons are found, reside, or transact business to collect the penalty and such court shall have jurisdiction to hear and decide such action. In such action, the validity and amount of such penalty shall not be subject to review.”

(b) Section 9(b) of the Food Stamp Act of 1977 (7 U.S.C. 2018(b)) is amended by—

(1) inserting “(1)” after the subsection designation; and

(2) adding at the end thereof the following new paragraph:

“(2)(A) A buyer or transferee (other than a bona fide buyer or transferee) of a retail food store or wholesale food concern that has been disqualified under section 12(a) may not accept or redeem coupons until the Secretary receives full payment of any penalty imposed on such store or concern.

“(B) A buyer or transferee may not, as a result of the sale or transfer of such store or concern, be required to furnish a bond under section 12(d).”

Prohibition.
Post, p. 1585.

Prohibition.
Ante, p. 1582.

LIABILITY FOR OVERISSUANCE OF COUPONS

SEC. 1533. Section 13(a) of the Food Stamp Act of 1977 (7 U.S.C. 2022(a)) is amended by—

(1) inserting “(1)” after the subsection designation; and

(2) adding at the end thereof the following new paragraph:

“(2) Each adult member of a household shall be jointly and severally liable for the value of any overissuance of coupons.”

COLLECTION OF CLAIMS

SEC. 1534. Section 13(b)(1)(B) of the Food Stamp Act of 1977 (7 U.S.C. 2022(b)(1)(B)) is amended by—

(1) striking out “may” and inserting in lieu thereof “shall”; and

(2) inserting “, unless the State agency demonstrates to the satisfaction of the Secretary that such other means are not cost effective” before the period at the end thereof.

FOOD STAMP INTERCEPT OF UNEMPLOYMENT BENEFITS

SEC. 1535. (a) Section 13 of the Food Stamp Act of 1977 (7 U.S.C. 2022) is amended by adding at the end thereof the following new subsection:

“(c)(1) As used in this subsection, the term ‘uncollected overissuance’ means the amount of an overissuance of coupons, as determined under subsection (b)(1), that has not been recovered pursuant to subsection (b)(1).

“(2) A State agency may determine on a periodic basis, from information supplied pursuant to section 3(b) of the Wagner-Peyser

Act (29 U.S.C. 49b(b)), whether an individual receiving compensation under the State's unemployment compensation law (including amounts payable pursuant to an agreement under a Federal unemployment compensation law) owes an uncollected overissuance.

"(3) A State agency may recover an uncollected overissuance—

"(A) by—

"(i) entering into an agreement with an individual described in paragraph (2) under which specified amounts will be withheld from unemployment compensation otherwise payable to the individual; and

"(ii) furnishing a copy of the agreement to the State agency administering the unemployment compensation law; or

"(B) in the absence of an agreement, by obtaining a writ, order, summons, or other similar process in the nature of garnishment from a court of competent jurisdiction to require the withholding of amounts from the unemployment compensation."

Ante, p. 1580.

(b)(1) Section 11(e) of the Food Stamp Act of 1977 (7 U.S.C. 2020(e)), as amended by section 1526, is amended by adding at the end thereof the following new paragraph:

Ante, p. 1583.

"(24) at the option of the State, for procedures necessary to obtain payment of uncollected overissuance of coupons from unemployment compensation pursuant to section 13(c)."

(2) Section 3(b) of the Wagner-Peyser Act (29 U.S.C. 49b(b)) is amended by—

(A) striking out "or" the second place it appears and inserting in lieu thereof a comma; and

(B) inserting after "such Act," the following: "or of a State agency charged with the administration of the food stamp program in a State under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.)."

(3) Section 303(d) of the Social Security Act (42 U.S.C. 503(d)) is amended by—

(A) redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively; and

(B) inserting after paragraph (1) the following new paragraph:

"(2)(A) For purposes of this paragraph, the term 'unemployment compensation' means any unemployment compensation payable under the State law (including amounts payable pursuant to an agreement under a Federal unemployment compensation law).

"(B) The State agency charged with the administration of the State law—

Ante, p. 1583.

"(i) may require each new applicant for unemployment compensation to disclose whether the applicant owes an uncollected overissuance (as defined in section 13(c)(1) of the Food Stamp Act of 1977) of food stamp coupons,

"(ii) may notify the State food stamp agency to which the uncollected overissuance is owed that the applicant has been determined to be eligible for unemployment compensation if the applicant discloses under clause (i) that the applicant owes an uncollected overissuance and the applicant is determined to be so eligible,

"(iii) may deduct and withhold from any unemployment compensation otherwise payable to an individual—

"(I) the amount specified by the individual to the State agency to be deducted and withheld under this clause,

TITLE XVIII—GENERAL EFFECTIVE DATE

EFFECTIVE DATE

7 USC 1281 note.

SEC. 1801. Except as otherwise provided in this Act, this Act and the amendments made by this Act shall become effective on the date of the enactment of this Act.

Approved December 23, 1985.

LEGISLATIVE HISTORY—H.R. 2100 (S. 1714):

HOUSE REPORTS: No. 99-271 Pt. I (Comm. on Agriculture) and Pt. II (Comm. on Merchant Marine and Fisheries) and No. 99-447 (Comm. of Conference).

SENATE REPORT No. 99-145 accompanying S. 1714 (Comm. on Agriculture, Nutrition, and Forestry).

CONGRESSIONAL RECORD, Vol. 131 (1985):

Sept. 20, 26, Oct. 1-3, 7, 8, considered and passed House.

Oct 25, 28-31, Nov. 1, 18-22, S. 1714 considered in Senate.

Nov. 23, H.R. 2100 considered and passed Senate, amended, in lieu of S. 1714.

Dec. 18, House and Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 21, No. 52 (1985):

Dec. 23, Presidential statement.



FOOD SECURITY ACT OF 1985

REPORT

OF THE

COMMITTEE ON AGRICULTURE

TO ACCOMPANY

H.R. 2100

[Including cost estimate of the Congressional Budget Office]

together with

SUPPLEMENTAL AND MINORITY VIEWS



SEPTEMBER 13, 1985.—Ordered to be printed

No material re Social Security in this report.

FOOD SECURITY ACT OF 1985

SEPTEMBER 18, 1985.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. JONES of North Carolina, from the Committee on Merchant Marine and Fisheries, submitted the following

REPORT

[To accompany H.R. 2100]

[Including cost estimate of the Congressional Budget Office]

The Committee on Merchant Marine and Fisheries, to whom was referred the bill H.R. 2100, the Food Security Act of 1985, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments are as follows:

On page 274, strike lines 15-14 and insert:

EFFECT ON OTHER LAWS

SEC. 1141. Nothing in this Act shall be construed as exempting export activities from the cargo preference law except to the extent those activities were exempt under Public Law 95-501 (7 U.S.C. 1707a(b)) before September 13, 1985.

On page 367, strike out line 15 and insert in lieu thereof:

bilitation, or construction of any single building or facility. To the extent practicable, the aquaculture research, development, and demonstration centers established under this subsection shall be geographically located so that they are representative of the regional aquaculture opportunities in the United States.

(5) in the first sentence of subsection (e), inserting "the House Committee on Merchant Marine and Fisheries," after "House Committee on Agriculture,".

On page 516, beginning on line 10, insert the following:

No material re Social Security in this report.

AGRICULTURE, FOOD, TRADE, AND
CONSERVATION ACT OF 1985

R E P O R T

OF THE

COMMITTEE ON
AGRICULTURE, NUTRITION, AND FORESTRY
UNITED STATES SENATE

together with

ADDITIONAL VIEWS

TO ACCOMPANY

S. 1714



SEPTEMBER 30, 1985.—Ordered to be printed

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

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CARL P. ROSE, *General Counsel and Staff Director for the Minority*

WARREN B. OXFORD, *Printer/Chief Clerk*

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The Committee's provision responds, in part, to the GAO and OIG recommendation by permitting—rather than requiring, as the GAO and OIG recommended—the use of benefit offset to recover overissuances (caused by State agency error) from current recipients. The rate of collection in such cases—as already provided in the statute for other instances of nonfraud overissuances—is limited to \$10 or 10 percent of the households' monthly allotment, whichever would result in faster collection.

The GAO also noted that in the AFDC program, the State is required to take appropriate action under State law to recover overissuances from households no longer participating in the program, while in the food stamp program such collection activities are optional, at the discretion of the State.

The GAO also recommended that, in order to ensure more aggressive collection efforts, the Department of Agriculture should require States to take any and all appropriate action under State law to recover overissuances against the income or resources of individuals no longer receiving benefits. Current efforts consist primarily of "demand letters" seeking repayment.

The Committee's provision requires States to use other means of collection (aside from cash payment or allotment recoupment) to collect claims arising from intentional program violations, unless the State can demonstrate that such other collection methods are not cost effective.

The GAO also identified collection techniques being used in other programs that also could be used in the food stamp program to increase collections from households not already subject to the recoupment of future benefits. These techniques included State retention (or interception) of State income tax refunds, Federal interception of Federal tax refunds, use of small claims courts and collection agencies, and generally more aggressive collection procedures. An additional method of collection has been provided in the Committee's bill, and is described elsewhere, to permit States to recover overissuances from unemployment compensation benefits.

Food stamp intercept of unemployment benefits—(Sec. 1434)

As a part of expanded efforts to improve collection of food stamp overissuances, the Committee adopted a provision to permit the establishment of intercept systems to recover from unemployment compensation benefits food stamp overissuances resulting from fraud or intentional misrepresentation.

The provision parallels one adopted in the Omnibus Budget Reconciliation Act of 1981 for the aid to families with dependent children program. That program has required States to establish such a system to recover delinquent child support payments. However, the provision adopted by the Committee with respect to food stamp overissuances is optional, at the discretion of the States.

As noted consistently by officials from the General Accounting Office, the rate of recovery of overissuances due to fraud has been very low, usually less than 1 percent.

The Congress adopted several provisions in 1981 and 1982 to strengthen collections, and early indications are that these are permitting greater collection of overissuances.

Collection of claims

Section 1433 amends section 13(b) of the Food Stamp Act of 1977 to require States to use other means of collection to collect claims arising from intentional program violations, which are not collected through cash payment or allotment reduction, unless the State agency can demonstrate that other collection methods are not cost-effective. Under current law, State agencies are authorized to use alternative collection methods to pursue these claims, but are not required to do so.

In addition, section 1433 allows State agencies to reduce household allotments to collect claims arising from State agencies' errors.

Food stamp intercept of unemployment benefits

Section 1434 amends sections 13, 11(e), 16(a), and 18(e) of the Food Stamp Act of 1977 to authorize the intercept of unemployment compensation benefits to collect claims arising from a food stamp overissuance caused by an intentional program violation. State agencies that elect this option would determine if individuals against whom such claims had been established were due unemployment compensation benefits. In addition, State unemployment compensation agencies could ask applicants for unemployment compensation whether they owe a claim based on an intentional program violation, and inform the State food stamp agency about individuals who indicate that they owe such a claim and are eligible for unemployment compensation. State food stamp agencies would obtain authorization for an intercept of unemployment compensation benefits either by securing the consent of the individual against whom a claim has been made or obtaining permission from a court. The State food stamp agency would provide this authorization to the State agency that administers the unemployment compensation program. This agency would deduct the amount of the food stamp claim from the individual's unemployment compensation benefits and transfer the withheld amount to the State food stamp agency. State food stamp agencies would be required to reimburse the State agencies that administer unemployment compensation programs for their administrative costs incurred in intercepting benefits. States would retain 50 percent of the amount of claims recovered through such intercepts.

Administrative and judicial review

Section 1435 amends section 14(a) of the Food Stamp Act of 1977 by changing the criterion a retail store, wholesale food concern, or State agency would need to meet to obtain a judicial stay of an administrative action of the Secretary of Agriculture. Under current law, a store, concern, or State agency can obtain a judicial stay if it can show that irreparable injury would result if the administrative action remained in force. The provision would require the petitioner to show that it is likely to prevail on the merits of the case.

In addition, the section corrects a typographical error in section 14(a) of the Act.

State agency would have sole responsibility for determining which eligibility factors other than those required by the Secretary (i.e., gross included income, alien status, utility expenses in certain situations, medical expenses, Social Security Numbers, residency, identity, and questionable information that affects eligibility or benefit amounts) will be verified. This part of the provision enhances a State agency's ability to reduce fraud, waste, and abuse through its more detailed knowledge of the caseload.

State agencies would be required to mandate photographic identification cards whenever the Secretary and the Department's Inspector General determine that their use would be cost effective. Currently, State agencies are required to mandate photo IDs when their use has been determined to protect program integrity. The provision should result in an increase in mandatory photo ID use and diminished fraud and abuse.

State agencies would be required to establish fraud detection units in any project area with 5,000 or more participating households. It is estimated that there are about 250 such project areas. Although the provision represents a newly-mandated administrative activity, it is one that many State agencies are already performing. Some State agencies would be able to satisfy the requirement by designating existing personnel as fraud detection units but others would have to shift or hire personnel for this purpose.

The Committee's bill would establish liability against State agencies for interest on any food stamp claims assessed against them. The liability would begin at the point at which administrative review procedures, if any, were completed. The provision somewhat mitigates current Administration policy which institutes a claim for interest beginning 30 days after a claim is established. Interest would accumulate during any judicial review. The bill also revises the error rate liability calculation to tie it more directly to Federal dollars lost through errors rather than using a formula based on administrative costs. The effect of the provision would increase most State agencies' liability, especially where error rates exceed 7 percent.

State agencies would be required to use other means of collection (e.g., collection agents) to recover fraud/intentional misrepresentation claims if they cannot be collected through direct payments or allotment reductions, unless the State agency can demonstrate that it would not be cost effective to do so. Also, State agencies would be authorized to use allotment reduction to recover overissuances stemming from State agencies' errors. The new requirement and authority would add to State agencies' claims collection activity.

State agencies would have the option of covering overissuances through offsets against unemployment benefits. State agencies would have to either enter into an agreement with the unemployment compensation recipient or obtain a court order. The State agency would be compensated for this and other activities voluntarily entered into, including reimbursements to unemployment compensation authorities, through retention of 50 percent of any amounts recovered.

State agencies could be required by the Secretary to implement new certification procedures or modify existing procedures in project areas where the Department's Inspector General deter-

mines through the use of quality control information that error rates impair program integrity. This provision would represent an initial workload burden on State agencies that would moderate upon full implementation.

The Committee adopted several other proposals which impact upon State agencies by either simplifying current procedures or expanding State agencies' flexibility to make administrative decisions. For example, the monthly reporting/retrospective budgeting requirements would be revised to align them more closely to those of the AFDC program and to expand State agencies' options.

The bill contains State agency options for categorical eligibility and standardized benefits. State agencies would have the option to consider households where all members receive AFDC, SSI, or benefits under titles I, X, XIV, or XVI of the Social Security Act to be categorically eligible for the Food Stamp Program to the extent such households' gross income does not exceed 130 percent of the poverty line. While this provision would reduce State agencies' certification burden somewhat, it would have no effect on benefit calculations. The option to standardize benefits to households with AFDC, SSI, or Medicaid recipients would represent a substantial early workload for State agencies who opt for it. Categories of households would have to be defined, average benefits calculated, evidence furnished to the Department that the average benefit for each household category is approximately equal to actual benefits, and households notified of changes. Upon completion of start-up procedures, however, the State agency's workload for these categories of households should be substantially reduced.

State agencies would be provided the flexibility of issuing food stamps over the entire month rather than, as now required by regulation, only during the first 15 days of the month. The only stipulation would be that no household receive its food stamps more than 40 days after its prior issuance due to staggered issuance procedures.

One provision would only affect the food stamp State agency in the Commonwealth of Puerto Rico. It would permit the Commonwealth to continue to provide food assistance to its citizens in the form of cash or to switch, at its option, to a noncash form of assistance. Also, the Commonwealth's annual plan of providing food assistance would be due April of each year rather than July 1.

In a final category of provisions which impact on State agencies is one designed to enhance program services to those people it is intended to assist. State agencies would be required to meet standards established by the Secretary for reviewing the hours certification and issuance offices are open and determining the adequacy of those hours for serving employed people. The provision does not represent a serious administrative task for State agencies but merely recognizes their responsibility to serve all eligible individuals.

The Committee's bill would have a general positive impact on participating retail stores by prohibiting financial institutions from charging them fees for food stamp redemptions. Most of the bill's provisions on retailers, however, are intended to enhance program integrity and would affect retailers who do not comply with program rules. The Committee's bill would improve the oversight of



FOOD SECURITY ACT
OF 1985

THE COMMITTEE OF CONFERENCE

SUBMITTED THE FOLLOWING

CONFERENCE REPORT

[To accompany H.R. 2100]



DECEMBER 17, 1985.—Ordered to be printed

- Sec. 1404. Responsibilities of the Secretary of Agriculture.*
- Sec. 1405. Joint Council on Food and Agricultural Sciences.*
- Sec. 1406. National Agricultural Research and Extension Users Advisory Board.*
- Sec. 1407. Federal-State partnership.*
- Sec. 1408. Report of the Secretary of Agriculture.*
- Sec. 1409. Competitive, special, and facilities research grants.*
- Sec. 1410. Grants for schools of veterinary medicine.*
- Sec. 1411. Research facilities.*
- Sec. 1412. Grants and fellowships for food and agricultural sciences education.*
- Sec. 1413. Food and human nutrition research and extension program.*
- Sec. 1414. Animal health and disease research.*
- Sec. 1415. Extension at 1890 land-grant colleges.*
- Sec. 1416. Grants to upgrade 1890 land-grant college extension facilities.*
- Sec. 1417. Research at 1890 land-grant colleges.*
- Sec. 1418. International agricultural research and extension.*
- Sec. 1419. International trade development centers.*
- Sec. 1420. Agricultural information exchange with Ireland.*
- Sec. 1421. Studies.*
- Sec. 1422. Authorization for appropriations for certain agricultural research programs.*
- Sec. 1423. Authorization for appropriations for extension education.*
- Sec. 1424. Contracts, grants, and cooperative agreements.*
- Sec. 1425. Indirect costs.*
- Sec. 1426. Cost-reimbursable agreements.*
- Sec. 1427. Technology development.*
- Sec. 1428. Supplemental and alternative crops.*
- Sec. 1429. Aquaculture.*
- Sec. 1430. Rangeland research.*
- Sec. 1431. Authorization for appropriations for Federal agricultural research facilities.*
- Sec. 1432. Dairy goat research.*
- Sec. 1433. Grants to upgrade 1890 land-grant college research facilities.*
- Sec. 1434. Soybean Research Advisory Institute.*
- Sec. 1435. Smith-Lever Act.*
- Sec. 1436. Market expansion research.*
- Sec. 1437. Pesticide resistance study.*
- Sec. 1438. Expansion of education study.*
- Sec. 1439. Critical agricultural materials.*
- Sec. 1440. Special grants for financially stressed farmers and dislocated farmers.*
- Sec. 1441. Annual report on family farms.*
- Sec. 1442. Conforming amendments to tables of contents.*

Subtitle B—Human Nutrition Research

- Sec. 1451. Findings.*
- Sec. 1452. Human nutrition research.*
- Sec. 1453. Dietary assessment and studies.*

Subtitle C—Agricultural Productivity Research

- Sec. 1461. Definitions.*
- Sec. 1462. Findings.*
- Sec. 1463. Purposes.*
- Sec. 1464. Information study.*
- Sec. 1465. Research projects.*
- Sec. 1466. Coordination.*
- Sec. 1467. Reports.*
- Sec. 1468. Agreements.*
- Sec. 1469. Dissemination of data.*
- Sec. 1470. Authorization for appropriations.*
- Sec. 1471. Effective date.*

TITLE XV—FOOD STAMP AND RELATED PROVISIONS

Subtitle A—Food Stamp Provisions

- Sec. 1501. Publicly operated community mental health centers.*
- Sec. 1502. Determination of food sales volume.*
- Sec. 1503. Thrifty food plan.*
- Sec. 1504. Definitions of the disabled.*

- Sec. 1505. State and local sales taxes.*
- Sec. 1506. Relation of food stamp and commodity distribution programs.*
- Sec. 1507. Categorical eligibility.*
- Sec. 1508. Third party payments.*
- Sec. 1509. Excluded income.*
- Sec. 1510. Child support payments.*
- Sec. 1511. Deductions from income.*
- Sec. 1512. Income from self-employment.*
- Sec. 1513. Retrospective budgeting and monthly reporting simplification.*
- Sec. 1514. Resources limitation.*
- Sec. 1515. Disaster task force.*
- Sec. 1516. Eligibility disqualifications.*
- Sec. 1517. Employment and training program.*
- Sec. 1518. Staggering of coupon issuance.*
- Sec. 1519. Alternative means of coupon issuance.*
- Sec. 1520. Simplified applications and standardized benefits.*
- Sec. 1521. Disclosure of information submitted by retail stores.*
- Sec. 1522. Credit unions.*
- Sec. 1523. Charges for redemption of coupons.*
- Sec. 1524. Hours of operation.*
- Sec. 1525. Certification of information.*
- Sec. 1526. Fraud detection.*
- Sec. 1527. Verification.*
- Sec. 1528. Photographic identification cards.*
- Sec. 1529. Eligibility of the homeless.*
- Sec. 1530. Expanded food and nutrition education program.*
- Sec. 1531. Food stamp program information and simplified application at social security administration offices.*
- Sec. 1532. Retail food stores and wholesale food concerns.*
- Sec. 1533. Liability for overissuance of coupons.*
- Sec. 1534. Collection of claims.*
- Sec. 1535. Food stamp intercept of unemployment benefits.*
- Sec. 1536. Administrative and judicial review.*
- Sec. 1537. State agency liability, quality control, and automatic data processing.*
- Sec. 1538. Quality control studies and penalty moratorium.*
- Sec. 1539. Geographical error-prone profiles.*
- Sec. 1540. Pilot projects.*
- Sec. 1541. Authorization ceiling; authority to reduce benefits.*
- Sec. 1542. Transfer of funds.*
- Sec. 1543. Puerto Rico block grant.*

Subtitle B—Commodity Distribution Provisions

- Sec. 1561. Transfer of section 32 commodities.*
- Sec. 1562. Commodity distribution programs.*
- Sec. 1563. Emergency feeding organizations—definitions.*
- Sec. 1564. Temporary emergency food assistance program.*
- Sec. 1565. Repeal of provisions relating to the food security wheat reserve.*
- Sec. 1566. Report on commodity displacement.*
- Sec. 1567. Distribution of surplus commodities; processing agreements.*
- Sec. 1568. State cooperation.*
- Sec. 1569. Authorization for funding and related provisions.*
- Sec. 1570. Reauthorizations.*
- Sec. 1571. Report.*

Subtitle C—Nutrition and Miscellaneous Provisions

- Sec. 1581. School lunch pilot project.*
- Sec. 1582. Gleaning of fields.*
- Sec. 1583. Issuance of rules.*
- Sec. 1584. Nutrition education findings.*
- Sec. 1585. Purpose.*
- Sec. 1586. Program.*
- Sec. 1587. Administration.*
- Sec. 1588. Authorization of appropriations.*
- Sec. 1589. Nutrition monitoring.*

(2) inserting “, unless the State agency demonstrates to the satisfaction of the Secretary that such other means are not cost effective” before the period at the end thereof.

FOOD STAMP INTERCEPT OF UNEMPLOYMENT BENEFITS

SEC. 1535. (a) Section 13 of the Food Stamp Act of 1977 (7 U.S.C. 2022) is amended by adding at the end thereof the following new subsection:

“(c)(1) As used in this subsection, the term ‘uncollected overissuance’ means the amount of an overissuance of coupons, as determined under subsection (b)(1), that has not been recovered pursuant to subsection (b)(1).

“(2) A State agency may determine on a periodic basis, from information supplied pursuant to section 3(b) of the Wagner-Peyser Act (29 U.S.C. 49b(b)), whether an individual receiving compensation under the State’s unemployment compensation law (including amounts payable pursuant to an agreement under a Federal unemployment compensation law) owes an uncollected overissuance.

“(3) A State agency may recover an uncollected overissuance—

“(A) by—

“(i) entering into an agreement with an individual described in paragraph (2) under which specified amounts will be withheld from unemployment compensation otherwise payable to the individual; and

“(ii) furnishing a copy of the agreement to the State agency administering the unemployment compensation law; or

“(B) in the absence of an agreement, by obtaining a writ, order, summons, or other similar process in the nature of garnishment from a court of competent jurisdiction to require the withholding of amounts from the unemployment compensation.”

(b)(1) Section 11(e) of the Food Stamp Act of 1977 (7 U.S.C. 2020(e)), as amended by section 1526, is amended by adding at the end thereof the following new paragraph:

“(24) at the option of the State, for procedures necessary to obtain payment of uncollected overissuance of coupons from unemployment compensation pursuant to section 13(c).”

(2) Section 3(b) of the Wagner-Peyser Act (29 U.S.C. 49b(b)) is amended by—

(A) striking out “or” the second place it appears and inserting in lieu thereof a comma; and

(B) inserting after “such Act,” the following: “or of a State agency charged with the administration of the food stamp program in a State under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.),”.

(3) Section 303(d) of the Social Security Act (42 U.S.C. 503(d)) is amended by—

(A) redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively; and

(B) inserting after paragraph (1) the following new paragraph:

"(2)(A) For purposes of this paragraph, the term 'unemployment compensation' means any unemployment compensation payable under the State law (including amounts payable pursuant to an agreement under a Federal unemployment compensation law).

"(B) The State agency charged with the administration of the State law—

"(i) may require each new applicant for unemployment compensation to disclose whether the applicant owes an uncollected overissuance (as defined in section 13(c)(1) of the Food Stamp Act of 1977) of food stamp coupons,

"(ii) may notify the State food stamp agency to which the uncollected overissuance is owed that the applicant has been determined to be eligible for unemployment compensation if the applicant discloses under clause (i) that the applicant owes an uncollected overissuance and the applicant is determined to be so eligible,

"(iii) may deduct and withhold from any unemployment compensation otherwise payable to an individual—

"(I) the amount specified by the individual to the State agency to be deducted and withheld under this clause,

"(II) the amount (if any) determined pursuant to an agreement submitted to the State food stamp agency under section 13(c)(3)(A) of the Food Stamp Act of 1977, or

"(III) any amount otherwise required to be deducted and withheld from the unemployment compensation pursuant to section 13(c)(3)(B) of such Act, and

"(iv) shall pay any amount deducted and withheld under clause (iii) to the appropriate State food stamp agency.

"(C) Any amount deducted and withheld under subparagraph (B)(iii) shall for all purposes be treated as if it were paid to the individual as unemployment compensation and paid by the individual to the State food stamp agency to which the uncollected overissuance is owed as repayment of the individual's uncollected overissuance.

"(D) A State food stamp agency to which an uncollected overissuance is owed shall reimburse the State agency charged with the administration of the State unemployment compensation law for the administrative costs incurred by the State agency under this paragraph that are attributable to repayment of uncollected overissuance to the State food stamp agency to which the uncollected overissuance is owed."

(c)(1) The proviso of the first sentence of section 16(a) of the Food Stamp Act of 1977 (7 U.S.C. 2025(a)) is amended by striking out "section 13(b)(1) of this Act" and inserting in lieu thereof "subsections (b)(1) and (c) of section 13".

(2) The first sentence of section 18(e) of such Act (7 U.S.C. 2027(e)) is amended by striking out "section 13(b) of this Act" and inserting in lieu thereof "subsections (b) and (c) of section 13".

ADMINISTRATIVE AND JUDICIAL REVIEW

SEC. 1536. The last sentence of section 14(a) of the Food Stamp Act of 1977 (7 U.S.C. 2023(a)) is amended by—

(36) Food Stamp Intercept of Unemployment Benefits

The *Senate* amendment permits States to collect overpaid benefits in cases of intentional violation by having appropriate amounts withheld from any unemployment compensation due the individual.

Collection of these overissuances (if they have not been collected through reduction in the household's benefit allotment, repayment in cash, or other means) could be by agreement with the individual to have appropriate amounts withheld from any unemployment compensation due, or by court-ordered garnishment.

State food stamp agencies would reimburse unemployment compensation agencies for the cost of collection through the unemployment compensation system. As with other means of collection in cases of intentional violation, States would be authorized to retain 50 percent of any amounts collected through the unemployment compensation system. (Sec. 1434.)

(NOTE.—Social Security Act provisions dealing with unemployment compensation would be amended to allow for this method of collection and to allow the unemployment compensation agencies to require applicants for unemployment compensation to disclose whether they have received an overissuance of food stamps due to intentional violation of the Food Stamp Act or regulations and the overissuance has not been collected.)

The *House* bill contains no comparable provisions.

The *Conference* substitute adopts the *Senate* provisions.

(37) Administrative and Judicial Review

The *Senate* amendment revises the standard that States, retail food stores, and wholesale food concerns must meet in order to have a court temporarily stay an administrative action against them during the pendency of judicial review or any appeal. An applicant for a temporary stay would have to show a likelihood of prevailing on the merits of the case. (Sec. 1435.)

The *Senate* amendment also corrects a spelling error in the Act.

(NOTE.—Under existing law, an applicant must show irreparable injury in order to gain a temporary stay.)

The *House* bill contains no comparable provisions.

The *Conference* substitute adopts the *Senate* provision with an amendment to revise the standard of review to include consideration of irreparable harm and likelihood of prevailing on the merits of the case.

(38) State Agency Liability, Quality Control, and Automatic Data Processing

(a) The *Senate* amendment revises the method of calculating the fiscal sanction owed by States with rates of erroneous payment in excess of 5 percent. Effective for erroneous payments made in FY 1986 and following fiscal years, States would be liable for:

75 percent of the value of erroneous payments made in excess of the 5-percent threshold, as long as the State's error rate does not exceed 7 percent; and

Finder's Aid
P.L. 99-221 (99 Stat. 1735) Approved December 26, 1985
Cherokee Leasing Act

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>99 Stat.</u>	<u>S.Rep. 99-191</u>
Employment - Service in Employ of the United States - Return after Employment by Indian Tribal Organization	210(a)(5) (B)(i)(III)	3(b)(1)	1735	1
Employment - Service in Employ of the United States - Return after Employment by Indian Tribal Organization (technical amendment)	210(a)(5) (B)(i)(IV)	3(b)(2)	1735	1
Employment - Service in Employ of the United States - Return after Employment by Indian Tribal Organization (technical amendment)	210(a)(5) (B)(i)(V) New	3(b)(3)	1735	1



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Employment - Service in Employ of the United States - Return after Employment by Indian Tribal Organization (technical amendment)	210(a)(5) (B)(i)(V) New	3(b)(3)	1735	1



Public Law 99-221
99th Congress

An Act

To authorize the Cherokee Nation of Oklahoma to lease certain lands held in trust for up to ninety-nine years.

Dec. 26, 1985
[S. 1728]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Cherokee
Leasing Act.
25 USC 415
note.

SECTION 1. SHORT TITLE.

This Act may be cited as the "Cherokee Leasing Act".

SEC. 2. AUTHORIZATION FOR 99-YEAR LEASE.

The second sentence of subsection (a) of the first section of the Act entitled "An Act to authorize the leasing of restricted Indian lands for public, religious, educational, recreational, residential, business, and other purposes requiring the grant of long-term leases" approved August 9, 1955 (25 U.S.C. 415), is amended by inserting "lands held in trust for the Cherokee Nation of Oklahoma," after "the Twenty-nine Palms Band of Luiseno Mission Indians,".

SEC. 3. CERTAIN CIVIL SERVICE BENEFITS FOR FORMER FEDERAL EMPLOYEES WORKING FOR INDIAN TRIBES.

(a) Subsection (e) of section 105 of the Indian Self-Determination Act (25 U.S.C. 450i(a)) is amended by striking out "1985" and inserting instead "1988".

(b) Section 210(a)(5)(B)(i) of the Social Security Act (42 U.S.C. 410(a)(5)(B)(i)) and section 3121(b)(5)(B)(i) of the Internal Revenue Code of 1954 are each amended—

26 USC 3121.
98 Stat. 1122.
98 Stat. 1124.

- (1) by striking out "and" at the end of subclause (III),
- (2) by striking out "; or" at the end of the subclause (IV) and inserting in lieu thereof ", and", and
- (3) by adding after subclause (IV) the following:

"(V) if an individual performing service described in subparagraph (A) returns to the performance of such service after employment (by a tribal organization) to which section 105(e)(2) of the Indian Self-Determination Act applies, then the service performed for that tribal organization shall be considered service described in subparagraph (A); or".

25 USC 450i.

42 USC 410
note.

(c) The amendments made by subsection (b) apply to any return to the performance of service in the employ of the United States, or of an instrumentality thereof, after 1983.

Approved December 26, 1985.

LEGISLATIVE HISTORY—S. 1728:

SENATE REPORT No. 99-191 (Comm. on Indian Affairs).
CONGRESSIONAL RECORD, Vol. 131 (1985):

Dec. 3, considered and passed Senate.

Dec. 17, considered and passed House.

**AUTHORIZING THE CHEROKEE NATION OF OKLAHOMA TO
LEASE CERTAIN LANDS HELD IN TRUST FOR UP TO 99
YEARS**

NOVEMBER 19 (legislative day, NOVEMBER 18), 1985.—Ordered to be printed

Mr. ANDREWS, from the Select Committee on Indian Affairs,
submitted the following

R E P O R T

[To accompany S. 1728]

The Select Committee on Indian Affairs, to which was referred the bill (S. 1728) to authorize the Cherokee Nation of Oklahoma to lease certain lands held in trust for up to 99 years, having considered the same, reports favorably thereon with an amendment and recommends that the bill (as amended) do pass.

The amendment is as follows:

On page 2, after line 3, add the following:

SEC. 3. CERTAIN CIVIL SERVICE BENEFITS FOR FORMER FEDERAL EMPLOYEES WORKING FOR INDIAN TRIBES.

(a) Subsection (e) of section 105 of the Indian Self-Determination Act (25 U.S.C. 450i(a)) is amended by striking out "1985" and inserting instead "1988".

(b) Section 210(a)(5)(B)(i) of the Social Security Act (42 U.S.C. 410(a)(5)(B)(i)) and section 3121(b)(5)(B)(i) of the Internal Revenue Code of 1954 are each amended—

(1) by striking out "and" at the end of subclause (III),

(2) by striking out "; or" at the end of the subclause (IV) and inserting in lieu thereof ", and", and

(3) by adding after subclause (IV) the following:

"(V) if an individual performing service described in subparagraph (A) returns to the performance of such service after employment (by a tribal organization) to which section 105(e)(2) of

the Indian Self-Determination Act applies, then the service performed for that tribal organization shall be considered service described in subparagraph (A); or"

(c) The amendments made by subsection (b) apply to any return to the performance of service in the employ of the United States, or of an instrumentality thereof, after 1983.

PURPOSE

S. 1728 would amend the Act of August 9, 1955 (25 U.S.C. 415), to authorize the Cherokee Nation of Oklahoma to lease for ninety-nine years lands held in trust by the United States.

At present, the Cherokee Nation has authority only to lease land for a twenty-five year period, renewable for another twenty-five years. All leases require the approval of the Secretary of the Interior as trustee.

Enactment of S. 1728 will enable the Tribe to enter into a fifty-year lease, renewable for forty-nine years, for a total period of ninety-nine years. Many other tribes have this authority.

Passage of the bill will settle litigation between the Tribe and the Muskogee City/County Port Authority by permitting the Tribe to lease the Arkansas River bottom to the Authority for a longer period than presently permitted.

With the proposed amendment the time for terminating certain BIA employees' retirement rights is extended until 1988.

BACKGROUND

In 1835, about the time of the "Trail of Tears," the United States granted fourteen million acres in what is now northeastern Oklahoma to the Cherokee Nation. The land included the Arkansas River in its entirety, the lower branch of which forms the border between the Cherokees to the north and the Choctaws and Chickasaws to the south.

After the Allotment Act of 1889, their land was diminished. Since that time, there have been arguments about who owns the riverbed which should have ended with the Supreme Court ruling in *Choctaw Nation of Oklahoma v. U.S.* The Court stated "that the United States intended to, and did convey, title to the bed of the Arkansas River. * * *" Of course, the Court also pointed out that the United States had a navigational easement under the Commerce Clause of the Constitution. This qualifying statement by the Court perhaps formed a basis for further litigation, both between the Tribe and the Port Authority and, also, the United States. This bill will settle the cases between the Tribe and the Port Authority. It will not, however, settle the case between the Tribe and the United States which is still pending. However, even if the Tribe does not prevail in the remaining case, the case against the Port Authority will have been settled and commerce on the Arkansas River will not be impeded.

This bill will enable the Tribe to lease land that is adjoining the river and in the river bottom to the Muskogee Port Authority for \$50,000 for a primary term of 50 years with an option for an addi-

tional 49 years for an additional \$50,000. Under present law, as set forth in 25 CFR 162.8(a), they would be limited to 25 years.

There is presently litigation regarding the leasing of the riverbed for mineral exploration.

LEGISLATIVE HISTORY

S. 1728 was introduced by Senator Nickles, for himself and Senator Boren on October 2, 1985. A companion bill, H.R. 3444, had been introduced on September 26, 1985, by Representative Synar, for himself and Representative Jones. That bill is identical to S. 1728. The Select Committee on Indian Affairs held a hearing on October 23, 1985. Testimony was presented by the Administration, the Cherokee Nation and two other tribes.

COMMITTEE RECOMMENDATIONS AND TABULATION OF VOTE

The Select Committee on Indian Affairs, in open business session on November 7, 1985, by a unanimous vote of a quorum present, recommends that the Senate pass S. 1728, as amended.

COMMITTEE AMENDMENT

The Committee recommends an amendment. Section 3 amends section 105(e) of the Indian Self-Determination and Education Assistance Act to extend to 1988, the termination date of the authority for Federal employees to elect to retain certain of their employee rights and benefits when they become employed by a tribe. Section 3 also amends section 210(b)(5)(B)(i) of the Social Security Act and section 3121(b)(5)(B)(i) of the Internal Revenue Code of 1954 to permit persons who have left Federal employment to work for Indian tribes or tribal organizations or Alaska Native entities under the provisions of the Indian Self-Determination and Education Assistance Act to be exempted from the requirements that they participate in the Social Security program when a tribe retrocedes a contract or the Secretary of the Department of Health and Human Services reassumes the health service function.

SECTION-BY-SECTION ANALYSIS

There are two sections. Section 1 authorizes the leases to extend to 99 years. Section 2 is the amendment described above.

COST AND BUDGETARY CONSIDERATIONS

The cost estimate for S. 1728, as amended, as provided by the Congressional Budget Office, is set forth below:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, November 12, 1985.

HON. MARK ANDREWS,
*Chairman, Select Committee on Indian Affairs, U.S. Senate, Hart
Senate Office Building, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed S. 1728, the Cherokee Leasing Act, as amended and ordered

reported by the Senate Select Committee on Indian Affairs, November 7, 1985.

We estimate that enactment of this bill would result in no significant cost to the federal government, and in no cost to state or local governments. Section 2 of the bill would enable the Cherokee Nation to enter into a 50-year lease, renewable for 49 years, of lands held in trust by the United States. Currently, authority exists only for 25-year leases, renewable for an additional 25 years. Section 3 would extend through calendar year 1988 the option of federal employees hired by Indian tribes, tribal organizations, or Alaska Native entities, to retain civil service benefits. The costs of those benefits, formerly borne by the federal government, are to be borne by the employer. This section also ensures that any such former federal employees rehired by the federal government would retain the benefit status of their previous federal employment. This provision would affect relatively few employees, and would not have a significant budget impact.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,
Sincerely,

ERIC HANUSHEK
(For Rudolph G. Penner).

EXECUTIVE COMMUNICATIONS

The only Executive Communication received by the Committee was in the form of testimony offered at the October 23, 1985 hearing by Hazel E. Elbert, Acting Deputy Assistant Secretary for Indian Affairs, Department of the Interior. The statement follows:

STATEMENT OF HAZEL E. ELBERT, ACTING DEPUTY ASSISTANT SECRETARY FOR INDIAN AFFAIRS, DEPARTMENT OF THE INTERIOR, BEFORE THE HEARING OF THE U.S. SENATE SELECT COMMITTEE ON INDIAN AFFAIRS ON S. 1728, A BILL "TO AUTHORIZE THE CHEROKEE NATION OF OKLAHOMA TO LEASE CERTAIN LANDS HELD IN TRUST FOR UP TO 99 YEARS"

Mr. Chairman, I am pleased to be here to present the views of the Department of the Interior on S. 1728, a bill "To authorize the Cherokee Nation of Oklahoma to lease certain lands held in trust for up to ninety-nine years."

We support the enactment of S. 1728.

S. 1728 would amend the Act of August 9, 1955 (25 U.S.C. 415), to authorize the Cherokee Nation of Oklahoma to lease for ninety-nine years, the lands held in trust by the United States. The Cherokee Nation is governed by a tribal constitution which was approved on September 5, 1975 by the Commissioner of Indian Affairs.

Although the Cherokee Nation has existing authority to lease (with the Secretary's approval) its lands for a 25-year period, with an additional 25-year renewal, S. 1728 would grant it the authority to lease its trust lands for up to

ninety-nine years. A number of other tribes have similar authority under the provisions of 25 U.S.C. 415.

Enactment of S. 1728 would enable the Tribe to enter into a lease with the Muskogee City/County Port Authority for a 99-year period. The agreement, in effect, would serve to satisfy a dispute between the Cherokee Nation and the Port Authority.

A lease between the Cherokee Nation and the Muskogee City/County Port Authority has been approved for a 25-year period, with an option to renew for an additional 25 years. The permit covers approximately three acres. On execution of the 99-year lease, the pending litigation between the parties in the United States District Court for the Eastern District of Oklahoma, Case No. 81-318-C, and on appeal to the United States Court of Appeals, Tenth Circuit, under No. 83-2325, entitled *Cherokee Nation of Oklahoma v. Muskogee City/County Port Authority*, would be dismissed.


This concludes my prepared statement. I will now be happy to answer any questions you might have.

REGULATORY IMPACT STATEMENT

Paragraph II(B) of the Rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out the bill. The Committee believes that S. 1728, as amended, will have no regulatory or paperwork impact.

CHANGES IN EXISTING LAW

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, the Committee states as follows: It is the opinion of the Committee that it is necessary to dispense with the requirements of this subsection to expedite the business of the Senate.





Finder's Aid
P.L. 99-272 (100 Stat. 82) Approved April 7, 1986
Consolidated Omnibus Budget Reconciliation Act of 1985

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-241 Part 1</u>	<u>H.Rep. 99-241 Part 3</u>	<u>S.Rep. 99-146</u>	<u>H.C.Rep. 99-453</u>
Trust Funds - Report of Trustees - Reference to Economic Assumptions	201(c)	9213(a)	180	—	—	307	524, 594
Child's Benefits - Extension of Reentitlement Period to Childhood Disability	202(d)(6)(E)	12107(a)	286	—	—	330	588
Child's Benefits - Dependency Test for Adopted Great Grandchildren	202(d)(8)(D) (ii)(III)	12104(a)	285	—	—	330	587
Reduction of Benefits - Work Deductions of Auxiliaries in Disability Cases (technical amendment)	203(a)(4)	12108(a)(1)	286	—	—	—	—
Reduction of Benefits - Work Deductions of Auxiliaries in Disability Cases (technical amendment)	203(a)(6)	12108(a)(2) (A)	286	—	—	—	—
Reduction of Benefits - Work Deductions of Auxiliaries in Disability Cases	203(a)(6)	12108(a)(2) (B)	286	—	—	330	589
Overpayments - Direct Deposit to a Joint Account with Deceased Individual - Recovery	204(a)	12113(a)(1)	288	—	—	—	—
Overpayments - Direct Deposit to a Joint Account with Deceased Individual - Recovery (technical amendment)	204(a)(1) Redesignated as (a)(1)(A)	12113(a)(2)	288	—	—	—	—

*Note: There is no material relating to amendments to the Social Security Act contained in either House Report No. 99-241, Part 2, or House Report No. 99-300 which are listed in the "Legislative History" appearing at the end of P.L. 99-272.

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-241 Part 1</u>	<u>H.Rep. 99-241 Part 3</u>	<u>S.Rep. 99-146</u>	<u>H.C.Rep. 99-453</u>
Overpayments - Direct Deposit to a Joint Account with Deceased Individual - Recovery (technical amendment)	204(a)(2) Redesignated as (a)(1)(B)	12113(a)(2)	288	—	—	—	—
Overpayments - Direct Deposit to a Joint Account with Deceased Individual - Recovery (technical amendment)	204(a)(2) New	12113(a)(3)	288	—	—	328	592
Definition of Wages - Exemption of Retired Federal Judges on Active Duty	209	12112(a)	288	—	—	327	591
Definition of Employment - Medicare Qualified Government Employment - State and Local	210(p)	13205(b)(1)	316	6, 25, 97	—	389	632
Computation of Primary Insurance Amount - Elimination of Federal Register Publication Requirement	215(i)(4)	12105	286	—	—	330	588
State and Local Agreements - Maximum Period of Retroactivity - Governed by Date of Mailing to the Secretary	218(f)(1)	12110(a)	287	—	—	331	590
State and Local Agreements - Compensated on a Fee Basis - Effective Date of Mailing to the Secretary	218(u)(3)	12110(b)	287	—	—	331	590
State and Local Agreements - Optional Medicare Coverage of Current Employees	218(v) New	13205(c)	317	—	—	390	632
State and Local Agreements - Medicare Qualified Government Employment - Reporting and Payment of Taxes	218(w) New	13205(c)	318	—	—	390	633

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-241 Part 1</u>	<u>H.Rep. 99-241 Part 3</u>	<u>S.Rep. 99-146</u>	<u>H.C.Rep. 99-453</u>
Disability Insurance Benefits - Extension of Reentitlement Period to Childhood Disability (conforming amendment)	223(e)	12107(b)	286	—	—	—	—
Disability Insurance Benefits - Disability Offset Provisions (technical correction)	224(a)(2)	12109(a)(1)	286	—	—	331	590
Disability Insurance Benefits - Disability Offset Provisions (technical amendment)	224(a)(2)(B) (iv)	12109(a)(2)	287	—	—	—	—
Entitlement to Hospital Insurance Benefits - Medicare Qualified Government Employment - State and Local (conforming amendment)	226(a)(2)(C) (i)	13205(b)(2) (A)	317	99	—	—	—
Entitlement to Hospital Insurance Benefits - Medicare Qualified Government Employment - State and Local (conforming amendment)	226(b)(2)(C) (ii)(I)	13205(b)(2) (A)	317	99	—	—	—
Entitlement to Hospital Insurance Benefits - Medicare Qualified Government Employment - State and Local (conforming amendment)	226(g)	13205(b)(2) (C)(ii)	317	100	—	—	—
Entitlement to Hospital Insurance Benefits - End Stage Renal Disease - State and Local Employees (conforming amendment)	226A(a)(1)(A) (ii)	13205(b)(2) (B)	317	100	—	—	—
Entitlement to Hospital Insurance Benefits - End Stage Renal Disease - State and Local Employees (conforming amendment)	226A(a)(1)(B) (iii)	13205(b)(2) (B)	317	100	—	—	—

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-241 Part 1</u>	<u>H.Rep. 99-241 Part 3</u>	<u>S.Rep. 99-146</u>	<u>H.C.Rep. 99-453</u>
Grants to States for Unemployment Compensation Administration - Recovery of Overpayments (technical amendment)	303(a)(5)	12401(a)(1)	297	—	—	—	—
Grants to States for Unemployment Compensation Administration - Recovery of Overpayments	303(g) New	12401(a)(2)	297	—	—	343	609
AFDC - Third Party Liability for Care and Services Under Title XIX - Identification and Pursuit (technical amendment)	402(a)(26)(A)	12304(a)(1)	293	—	—	—	—
AFDC - Third Party Liability for Care and Services Under Title XIX - Identification and Pursuit (technical amendment)	402(a)(26)(B)	12304(a)(2)	293	—	—	—	—
AFDC - Third Party Liability for Care and Services Under Title XIX - Identification and Pursuit	402(a)(26)(C) New	12304(a)(3)	293	—	—	312	604
AFDC - Automation Requirements - Penalty for Late State Implementation	402(e)(2)(C) New	12303(a)	292	—	—	336	602
Foster Care, Adoption Assistance and Transitional Independent Living (conforming amendment)	470	12307(d)	297	—	—	—	—
Foster Care and Adoption Assistance - Medicaid Coverage	473(b)	12305(a)	293	—	—	341	605
Foster Care and Adoption Assistance - Medicaid Coverage (conforming amendment)	473(c)(2)(A)	12305(b)(1) (A)	293	—	—	—	—
Foster Care and Adoption Assistance - Medicaid Coverage (conforming amendment)	473(c)(2)	12305(b)(1) (B)	293	—	—	—	—

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H. Rep. 99-241 Part 1</u>	<u>H. Rep. 99-241 Part 3</u>	<u>S. Rep. 99-146</u>	<u>H.C. Rep. 99-453</u>
Foster Care - Independent Living Initiatives - Payments to States (technical amendment)	474(a)(3)	12307(c)(1)	296	—	—	—	—
Foster Care - Independent Living Initiatives - Payments to States	474(a)(4) New	12307(c)(2)	296	—	—	340	607
Foster Care - Payments to States - Extension of Voluntary Placement, and Ceiling and Trigger Provisions	474(b)(1)	12306(a)(1)	294	—	—	339	606
Foster Care - Payments to States - Extension of Voluntary Placement, and Ceiling and Trigger Provisions (technical amendment)	474(b)(2)(A) (ii)	12306(a)(2) (A)	294	—	—	—	—
Foster Care - Payments to States - Extension of Voluntary Placement, and Ceiling and Trigger Provisions	474(b)(2)(A) (iii)	12306(a)(2) (B)	294	—	—	339	606
Foster Care - Payments to States - Extension of Voluntary Placement, and Ceiling and Trigger Provisions (technical amendment)	474(b)(2)(A) (iv) Stricken	12306(a)(2) (B)	294	—	—	—	—
Foster Care - Payments to States - Extension of Voluntary Placement, and Ceiling and Trigger Provisions (technical amendment)	474(b)(2)(A) (v) Stricken	12306(a)(2) (B)	294	—	—	—	—
Foster Care - Payments to States - Extension of Voluntary Placement, and Ceiling and Trigger Provisions	474(b)(2)(B)	12306(a)(1)	294	—	—	339	606

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-241 Part 1</u>	<u>H.Rep. 99-241 Part 3</u>	<u>S.Rep. 99-146</u>	<u>H.C.Rep. 99-453</u>
Foster Care - Payments to States - Extension of Voluntary Placement, and Ceiling and Trigger Provisions	474(b)(4)(B)	12306(a)(1)	294	—	—	339	606
Foster Care - Payments to States - Extension of Voluntary Placement, and Ceiling and Trigger Provisions	474(b)(5)(A)	12306(a)(3)(A)	294	—	—	339	606
Foster Care - Payments to States - Extension of Voluntary Placement, and Ceiling and Trigger Provisions	474(b)(5)(A)(ii)	12306(a)(3)(B)	294	—	—	339	606
Foster Care - Payments to States - Extension of Voluntary Placement, and Ceiling and Trigger Provisions	474(c)(1)	12306(b)	294	—	—	339	606
Foster Care - Payments to States - Extension of Voluntary Placement, and Ceiling and Trigger Provisions	474(c)(2)	12306(b)	294	—	—	339	606
Foster Care - Independent Living Initiatives - Definition of Case Plan	475(1)	12307(b)	296	—	—	340	607
Adoption Assistance Agreement Medicaid Coverage (conforming amendment)	475(3)(A)	12305(b)(2)	293	—	—	—	606
Foster Care - Independent Living Initiatives	477 New	12307(a)	294	—	—	340	607
Maternal and Child Health Services - Children with Special Health Care Needs	501(a)(4)	9527(a)	219	—	—	325	559
Maternal and Child Health Services - Children with Special Health Care Needs	501(a)	9527(b)	219	—	—	325	559

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-241 Part 1</u>	<u>H.Rep. 99-241 Part 3</u>	<u>S.Rep. 99-146</u>	<u>H.C.Rep. 99-453</u>
Maternal and Child Health Services - Children with Special Health Care Needs	501(b)(1)(A)	9527(c)	219	--	--	325	559
Maternal and Child Health Services - Children with Special Health Care Needs	502(a)(2)(B)	9527(d)(1)	219	--	--	325	559
Maternal and Child Health Services - Children with Special Health Care Needs	502(a)(2)(B)	9527(d)(2)	219	--	--	325	559
Maternal and Child Health Services - Children with Special Health Care Needs	504(b)(1)	9527(e)	219	--	--	325	559
Maternal and Child Health Services - Children with Special Health Care Needs	509(b)	9527(e)	219	--	--	325	559
Administration - Disability Advisory Council Appointment Moratorium (conforming amendment)	706(a)	12102(g)(1) (A)	285	--	--	329	586
Administration - Disability Advisory Council Appointment Moratorium (conforming amendment)	706(e) New	12102(g)(1) (B)	285	--	--	329	586
Administration - Old-Age, Survivors and Disability Benefits - Effect of Early Delivery of Checks	708(c) New	12111(a)	287	--	--	331	591
Administration - Inadequate Trust Fund Balance - Formula Clarification	709(b)(1)	12106	286	--	--	330	588
General Provisions - Definitions - "Federal Percentage" - Promulgation by the Secretary	1101(a)(8)(P) (error in law, should be 1101 (a)(8)(B))	9528(a)(1)	219	--	--	318	557
General Provisions - Definitions - "Federal Percentage" - Promulgation by the Secretary	1101(a)(8)(P) (error in law, should be 1101 (a)(8)(B))	9528(a)(2)	219	--	--	318	557

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H. Rep. 99-241 Part 1</u>	<u>H. Rep. 99-241 Part 3</u>	<u>S. Rep. 99-146</u>	<u>H.C. Rep. 99-453</u>
General Provisions - Disability Demonstration Projects - Incorporation of Certain Reports into Secretary's Annual Report	1110(b)(3) New	12101(d)	283	--	--	329	586
General Provisions - Proficiency of Certain Health Care Personnel - Extension of Testing Authority	1123(a)	9303(b)(4)	189	--	--	--	517
Health Care Peer Review - Removal of One-Member Limitation on Health Maintenance Organizations	1153(b)(2)(A)	9404(a)	200	--	--	308	525
Health Care Peer Review - Peer Review Reimbursement	1153(c)(8)	9402(b)	201	--	--	308	525
Health Care Peer Review - Substitute Review Pending Termination of Peer Review Contract	1153(d)(4) New	9406(a)	201	--	--	309	526
Health Care Peer Review - Comparable Review for Health Maintenance Organizations and Competitive Medical Plans	1154(a)(1)	9405(a)	201	--	--	309	526
Health Care Peer Review - Denial of Payment Based Upon Quality of Service	1154(a)(2)	9403(a)(1)	200	--	--	310	527
Health Care Peer Review - Denial of Payment Based Upon Quality of Service	1154(a)(2)	9403(a)(2)	200	--	--	310	527
Health Care Peer Review - Approval of Assistant in Cataract Operation (conforming amendment)	1154(a)(8)	9307(b)	193	133	--	--	--
Health Care Peer Review - 100 Percent Peer Review for Certain Surgical Procedures (conforming amendment)	1154(a)(12) New	9401(a)	196	--	--	--	--

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-241 Part 1</u>	<u>H.Rep. 99-241 Part 3</u>	<u>S.Rep. 99-146</u>	<u>H.C.Rep. 99-453</u>
Health Care Peer Review - 100 Percent Peer Review for Certain Surgical Procedures	1164 New	9401(b)	196	4, 31	--	--	518
Supplemental Security Income - Federal Administration of State Supplementation	1616(b) (SSI)	12201(b)	290	--	--	--	597
Supplemental Security Income - Passthrough Relating to Optional State Supplementation	1618(f) (SSI) New	12201(a)	289	--	--	333	596
Supplemental Security Income - Overpayment - Direct Deposit to Joint Account with Deceased Individual - Recovery (technical amendment)	1631(b)(2) (SSI) Redesignated as (b)(3)	12113(b)	288	--	--	--	--
Supplemental Security Income - Overpayment - Direct Deposit to Joint Account with Deceased Individual - Recovery	1631(b)(2) (SSI) New	12113(b)	288	--	--	328	592
Supplemental Security Income - Overpayment - Direct Deposit to Joint Account with Deceased Individual - Recovery (technical amendment)	1631(b)(3) (SSI) Redesignated as (b)(4)	12113(b)	288	--	--	--	--
Supplemental Security Income - Overpayment - Direct Deposit to Joint Account with Deceased Individual - Recovery	1631(b)(4) (SSI) Redesignated as (b)(5)	12113(b)	288	--	--	--	--
Supplemental Security Income - Preservation of Benefit Status for Disabled Widows and Widowers (technical amendment)	1634 (SSI) Redesignated as 1634(a)	12202(a)(1)	290	--	--	--	--

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-241 Part 1</u>	<u>H.Rep. 99-241 Part 3</u>	<u>S.Rep. 99-146</u>	<u>H.C.Rep. 99-453</u>
Supplemental Security Income - Preservation of Benefit Status for Disabled Widows and Widowers	1634(b) (SSI) New	12202(a)(2)	290	—	—	331	597
Medicare - Coverage of Newly Hired State and Local Government Employees (conforming amendment)	1811(1)	13205(b)(2) (C)(i)	317	6, 25, — 89, 115	—	389	632
Medicare - Coverage of Newly Hired State and Local Government Employees (conforming amendment)	1811(2)	13205(b)(2) (C)(i)	317	6, 25, — 89, 116	—	389	632
Medicare - Change in Date for Promulgation of Inpatient Hospital Deductible	1813(b)(2)	9125(a)	168	—	—	—	470
Medicare - Hospice Care - Extension and Increase in Daily Rate	1814(i)(1)(B)	9123(b)(1)	168	3, 24, — 83, 86 89, 116	—	294	471
Medicare - Hospice Care - Extension and Increase in Daily Rate (technical amendment)	1814(i)(1)(C)	9123(b)(2)	168	116	—	—	—
Medicare - Trust Fund - Removal of Ban on Actuarial Comment on Economic Assumption	1817(b)	9213(b)	180	—	—	307	594
Medicare - Limiting the Penalty for Late Enrollment in Part A (technical amendment)	1818(c)(5)	9124(a)(1)	168	116	—	—	—
Medicare - Limiting the Penalty for Late Enrollment in Part A (technical amendment)	1818(c)(6)	9124(a)(2)	168	117	—	—	—
Medicare - Limiting the Penalty for Late Enrollment in Part A	1818(c)(7) New	9124(a)(3)	168	5, 24, — 83, 86, 117	—	—	472

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-241 Part 1</u>	<u>H.Rep. 99-241 Part 3</u>	<u>S.Rep. 99-146</u>	<u>H.C.Rep. 99-453</u>
Medicare - Waiver of Co-Payments - Second or Third Opinions	1833(a)(1)(D)	9401(b)second (2)(B)	199	--	--	--	519
Medicare - Clinical Diagnostic Laboratory Tests - Ceiling on Payments (conforming amendment)	1833(a)(1)(D) (1)	9303(b)(1)	189	--	--	--	--
Medicare - Waiver of Co-Payments - Second or Third Opinions (technical amendment)	1833(a)(1)(E)	9401(b)second (2)(A)	199	--	--	--	--
Medicare - Waiver of Co-Payments - Second or Third Opinions (technical amendment)	1833(a)(1)(F)	9401(b)second (2)(A)	199	--	--	--	--
Medicare - Waiver of Co-Payments - Second or Third Opinions	1833(a)(1)(G) New	9401(b)second (2)(A)	199	--	--	--	519
Medicare - Waiver of Co-Payments - Second or Third Opinions	1833(a)(2)(A)	9401(b)second (2)(C)	199	--	--	--	519
Medicare - Waiver of Co-Payments - Second or Third Opinions	1833(a)(2)(D)	9401(b)second (2)(D)	199	--	--	--	519
Medicare - Clinical Diagnostic Laboratory Tests - Ceiling on Payments (conforming amendment)	1833(a)(2)(D) (1)	9303(b)(1)	189	--	--	--	--
Medicare - Waiver of Co-Payments - Second or Third Opinions	1833(a)(3)	9401(b)second (2)(E)	199	--	--	--	519
Medicare - Waiver of Deductible - Second or Third Opinions (technical amendment)	1833(b)(3)	9401(b)second (1)	198	--	--	--	--
Medicare - Waiver of Deductible - Second or Third Opinions (technical amendment)	1833(b)(4)	9401(b)second (1)	199	--	--	--	--

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-241 Part 1</u>	<u>H.Rep. 99-241 Part 3</u>	<u>S.Rep. 99-146</u>	<u>H.C.Rep. 99-453</u>
Medicare - Waiver of Deductible - Second or Third Opinions	1833(b)(5) New	9401(b)second (1)	199	—	—	—	519
Medicare - Payment for Clinical Laboratory Services - Month of Annual Update	1833(h)	9303(a)(1)(A)	188	—	—	—	516
Medicare - Payment for Clinical Laboratory Services - Month of Annual Update	1833(h)(2)	9303(a)(1)(B)	188	—	—	—	516
Medicare - Payment for Clinical Laboratory Services - Ceiling on Rates (technical amendment)	1833(h)(4) Redesignated as (h)(4)(A)	9303(b)(2)	189	—	—	—	—
Medicare - Payment for Clinical Laboratory Services - Ceiling on Rates	1833(h)(4)(B) New	9303(b)(2)	189	—	—	—	516
Medicare - Payment for Clinical Laboratory Services - Non-Independent Laboratories - Method of Payment	1833(h)(5)(C)	9303(b)(3)	189	—	—	—	516
Medicare - Working Aged - Special Enrollment Periods (technical correction)	1837(i)(1)(A)	9219(a)(2)(A)	182	4, 118	—	—	—
Medicare - Working Aged - Special Enrollment Periods (technical correction)	1837(i)(2)(A)	9219(a)(2)(B)	182	4, 29, 119	—	—	495
Medicare - Working Aged - Special Enrollment Periods (technical correction)	1837(i)(2)(B)	9219(a)(2)(B)	182	4, 29 119	—	—	495
Medicare - Working Aged - Special Enrollment Periods (technical correction)	1837(i)(2)(C) Redesignated as (D)	9219(a)(2)(B)	182	4, 29 119	—	—	495

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-241 Part 1</u>	<u>H.Rep. 99-241 Part 3</u>	<u>S.Rep. 99-146</u>	<u>H.C.Rep. 99-453</u>
Medicare - Working Aged - Special Enrollment Periods (technical correction)	1837(i)(2)(C) New	9219(a)(2)(B)	182	4, 29 119	—	—	495
Medicare - Working Aged Provision - Special Enrollment Periods (conforming amendment)	1837(i)(3)	9201(c)(1)	171	29, 119	—	—	495
Medicare - Working Aged Provision - Effective Date of Enrollment During Special Enrollment Period (conforming amendment)	1838(e)	9201(c)(2)	171	29, 120	—	—	495
Medicare - Working Aged Provision - Premium Penalty (technical correction)	1839(b)	9219(a)(1)	182	4, 29 120	—	—	495
Medicare - Amounts of Part B Premiums - Effective Dates	1839(e)	9313(1)	194	2, 38, 83, 86, 90, 121	—	302, 410	505
Medicare - Amounts of Part B Premiums - Effective Dates	1839(f)(1)	9313(2)	194	2, 38, 83, 86, 90, 121	—	302, 410	505
Medicare - Amounts of Part B Premiums - Effective Dates	1839(f)(2)	9313(3)	194	2, 38, 83, 86, 90, 121	—	302, 410	505
Medicare - Part B - Trust Fund - Removal of Prohibition of Comments on Economic Assumptions by Actuaries	1841(b)	9213(b)	180	—	—	307	594
Medicare - Use of Carriers - Changing Customary and Prevailing Charge - Updates	1842(b)(3)(F)	9301(d)(1)(A)	188	—	—	301, 409	498

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-241 Part 1</u>	<u>H.Rep. 99-241 Part 3</u>	<u>S.Rep. 99-146</u>	<u>H.C.Rep. 99-453</u>
Medicare - Use of Carriers - Changing Customary and Prevailing Charge - Updates	1842(b)(3)	9301(d)(1)(B)	188	—	—	301, 409	498
Medicare - Use of Carriers - Changing Customary and Prevailing Charge - Updates	1842(b)(3)	9301(d)(1)(C)	188	—	—	301, 409	498
Medicare - Use of Carriers - Physician Payment (technical amendment)	1842(b)(4)(A) Redesignated as (A)(i)	9301(b)(1)(A) (i)	184	121	—	—	—
Medicare - Use of Carriers - Physician Payment - Extension of Certain Prevailing Charge Provisions Through 12/31/86	1842(b)(4)(A) (ii) New	9301(b)(1)(A) (ii)	184	2, 34, 83, 86, 122	—	301, 409	498
Medicare - Use of Carriers - Physician Payment - Extension of Certain Prevailing Charge Provisions Through 12/31/86	1842(b)(4)(A) (iii) New	9301(b)(1)(A) (ii)	184	2, 34, 83, 86, 122	—	301, 409	498
Medicare - Use of Carriers - Physician Payment (technical amendment)	1842(b)(4)(B) Redesignated as (B)(i)	9301(b)(1)(B) (i)	184	122	—	—	—
Medicare - Use of Carriers - Physician Payment - Extension of Certain Reasonable Charge Provisions through 12/31/86 (technical amendment)	1842(b)(4)(B) (ii) New	9301(b)(1)(B) (ii)	184	2, 34, 83, 86, 89, 122	—	301, 409	498
Medicare - Use of Carriers - Physician Payment (technical amendment)	1842(b)(4)(C) Redesignated as (C)(i)	9301(b)(1)(C) (i)	185	122	—	—	—
Medicare - Use of Carriers - Physician Payment - Extension of Certain Prevailing Charge Provisions Through 12/31/86 (conforming amendment)	1842(b)(4)(C) (i) As re- designated	9301(b)(1)(C) (ii)	185	122	—	—	—

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Medicare - Use of Carriers - Physician Payment - Extension of Certain Prevailing Charge Provisions Through 12/31/86	1842(b)(4)(C) (ii) New	9301(b)(1)(C) (iii)	185	2, 34, 83, 86, 89, 122	—	301, 409	498
Medicare - Use of Carriers - Physician Payment (technical amendment)	1842(b)(4)(D) Redesignated as (D)(i)	9301(b)(1)(D) (i)	185	122	—	—	—
Medicare - Use of Carriers - Physician Payment - Extension of Certain Customary Payment Provisions Through 12/31/86	1842(b)(4)(D) (i) As re- designated	9301(b)(1)(D) (i)	185	2, 34, 83, 86, 89, 122	—	301, 409	498
Medicare - Use of Carriers - Physician Payment - Extension of Certain Customary Payment Provisions Through 12/31/86	1842(b)(4)(D) (ii) New	9301(b)(1)(D) (ii)	185	123	—	301, 409	498
Medicare - Use of Carriers - Physician Payment - Extension of Certain Customary Payment Provisions Through 12/31/86	1842(b)(4)(D) (iii) New	9301(b)(1)(D) (ii)	185	—	—	301, 409	498
Medicare - Use of Carriers - Charges for Physician Services (technical correction)	1842(b)(7)(B) (ii)(III)	9219(b)(1)(A)	182	123	—	—	—
Medicare - Use of Carriers - Charges for Physician Services (technical correction)	1842(b)(7)(B) (iii)	9219(b)(2)(A)	183	123	—	—	—
Medicare - Use of Carriers - Inherent Reasonableness of Charges - Former Hospital Compensated Physicians	1842(b)(8) New	9304(a)	190	5, 38, 83, 86, 123	—	—	506

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Medicare - Use of Carriers - Post-Cataract Surgery Patients - Limitation on Payment	1842(b)(9) New	9306(a)	193	6, 42, 81, 83, 86, 91, 124	—	305, 411	512
Medicare - Use of Carriers - Participation Agreements - Effective Dates	1842(h)(1)	9301(d)(2)(A) (i)	188	—	—	—	501
Medicare - Use of Carriers - Participation Agreements - Effective Dates	1842(h)(1)	9301(d)(2)(A) (ii)	188	—	—	—	501
Medicare - Use of Carriers - Participation Agreements - Effective Dates	1842(h)(1)	9301(d)(2)(A) (iii)	188	—	—	—	501
Medicare - Use of Carriers - Participation Agreements - Effective Dates	1842(h)(1)	9301(d)(2)(B) (i)	188	—	—	—	501
Medicare - Use of Carriers - Participation Agreements - Effective Dates	1842(h)(1)	9301(d)(2)(B) (ii)	188	—	—	—	501
Medicare - Use of Carriers - Elimination of Physician Assignment Rate List	1842(i)(1) Stricken	9301(c)(3)(A)	187	35, 125	—	302	503
Medicare - Use of Carriers - Elimination of Physician Assignment Rate List (technical amendment)	1842(i)(2) Redesignated as (h)(4)	9301(c)(3)(D)	187	124	—	—	—
Medicare - Use of Carriers - Publication of Directory of Participa- ting Physicians - Change in Date	1842(h)(4) As redesign- ated	9301(d)(3)	188	—	—	302	503

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Medicare - Use of Carriers - Area Participating Physician Directories	1842(1)(2)	9301(c)(2)(A) (1)	186	35, 124	—	302	503
Medicare - Use of Carriers - Elimination of Physician Assignment Rate List (technical amendment)	1842(1)(2)	9301(c)(3)(B)	187	124	—	—	—
Medicare - Use of Carriers - Area Participating Physician Directories	1842(1)(2)	9301(c)(2)(A) (11)	186	35, 124	—	302	503
Medicare - Use of Carriers - Area Participating Physician Directories	1842(1)(2)	9301(c)(2)(B)	186	35, 124	—	302	503
Medicare - Use of Carriers - Elimination of Physician Assignment Rate List (technical amendment)	1842(1)(3)	9301(c)(3)(D) Redesignated as (h)(5)	187	124	—	—	—
Medicare - Use of Carriers - Elimination of Physician Assignment Rate List	1842(1)(3)	9301(c)(3)(C)	187	35, 124	—	302	503
Medicare - Use of Carriers - Area Participating Physician Directories	1842(1)(3)	9301(c)(2)(C) (1)	187	35, 124	—	302	503
Medicare - Use of Carriers - Area Participating Physician Directories	1842(1)(3)	9301(c)(2)(C) (11)	187	35, 124	—	302	503
Medicare - Use of Carriers - Elimination of Physician Assignment Rate List (technical amendment)	1842(1)(4)	9301(c)(3)(D) Redesignated as (h)(6)	187	124	—	—	—

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Medicare - Use of Carriers - Elimination of Physician Assignment Rate List	1842(i)(4)	9301(c)(3)(C)	187	35, 124	—	302	503
Medicare - Use of Carriers - Area Participating Physician Directories	1842(i)(4)	9301(c)(2)(D) (1)	187	35, 124	—	302	503
Medicare - Use of Carriers - Area Participating Physician Directories	1842(i)(4)	9301(c)(2)(D) (11)	187	35, 124	—	302	503
Medicare - Use of Carriers - Furnishing of Explanation of Participating Physician and Supplies Program	1842(h)(7) New	9301(c)(4)	187	34, 124	—	302	502
Medicare - Use of Carriers - Definition of Claim on an "Assignment- Related Basis"	1842(h)(8) New	9301(c)(4)	187	124	—	—	—
Medicare - Use of Carriers - Extension of Certain Provisions Monitoring Non- Participating Physician Charges	1842(j)(1)	9301(b)(2)	185	34, 125	—	301, 409	501
Medicare - Use of Carriers - Prohibition for Submitting Bill for Which Payment May Not Be Made - Assistant in Cataract Operations (conforming amendment)	1842(j)(2)	9307(c)(1)	194	125	—	—	—
Medicare - Use of Carriers - Prohibition for Submitting Bill for Which Payment May Not Be Made - Assistant in Cataract Surgery	1842(k) New	9307(c)(2)	194	5, 42, 81, 83, 86, 90, 126	—	304, 411	511

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				<u>H.Rep. 99-241 Part 1</u>	<u>H.Rep. 99-241 Part 3</u>	<u>S.Rep. 99-146</u>	<u>H.C.Rep. 99-453</u>
Medicare - Physician Payment Review Commission	1845 New	9305(a)	190	3, 36	—	—	504
Medicare - Relative Value Scale for Physician Services	1845(e) New	9305(b)	192	3, 36, 126	—	—	504
Medicare - Definitions - Durable Medical Equipment (technical correction)	1861(n)	9219(b)(1)(B)	182	4, 33 127	—	—	—
Medicare - Reasonable Cost - Hospital Return on Equity Capital - Cost Reporting Period (conforming amendment)	1861(v)(1)(B)	9107(b)(2)(A)	161	127	—	—	—
Medicare - Reasonable Cost - Hospital Return on Equity Capital - Rate of Return (conforming amendment)	1861(v)(1)(B)	9107(b)(2)(B)	161	127	—	—	—
Medicare - Reasonable Cost - Inpatient Services Consolidating Post Hospital Extended Care (technical correction)	1861(v)(1)(G) (i)	9219(b)(3)(A)	183	4, 33 128	—	—	—
Medicare - Reasonable Cost - Donations of State Property to Nonprofit Corporations - Asset Valuations (technical amendment)	1861(v)(1)(O) (1)	9110(a)(1)	162	128	—	—	—
Medicare - Reasonable Cost - Donations of State Property to Nonprofit Corporations - Asset Valuations	1861(v)(1)(O) (iv) New	9110(a)(2)	162	3, 22 83, 128	—	293	465
Medicare - Reasonable Cost - Hospital Rate of Return on Equity Capital	1861(v)(1)(P) New	9107(b)(1)	161	3, 20 83, 86, 89, 129	—	—	462

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Medicare - Prohibiting Limit on Increase in Direct Medical Evaluation Costs	1861(v)(1)(Q) New	9202(1)(1)	177	2, 19 89	—	292	486
Medicare - Exclusion from Coverage - Peer Review or Carrier Approval of Assistant in Cataract Operation (technical amendment)	1862(a)(13)	9307(a)(1)	193	129	—	—	—
Medicare - Exclusion from Coverage - Peer Review or Carrier Approval of Assistant in Cataract Operation (technical amendment)	1862(a)(14)	9307(a)(2)	193	129	—	—	—
Medicare - Exclusion from Coverage - Failure to Obtain Second Opinions (technical amendment)	1862(a)(14)	9401(c)(1)(A)	199	129	—	—	—
Medicare - Exclusion from Coverage - Peer Review or Carrier - Approval of Assistant in Cataract Operation	1862(a)(15) New	9307(a)(3)	193	5, 42, 81, 83 86, 90, 129	—	304, 411	511
Medicare - Exclusion from Coverage - Failure to Obtain Second Opinion (technical amendment)	1862(a)(15)	9401(c)(1)(B)	199	—	—	—	—
Medicare - Exclusion from Coverage - Failure to Obtain Second Opinion (conforming amendment)	1862(a)(16) New	9401(c)(1)(C)	199	—	—	—	—
Medicare - Extension of Secondary Payor Status Beyond Age 69	1862(b)(3)(A) (1)	9201(a)(1)	170	3, 28, 83, 86, 89, 130	—	297, 408	490
Medicare - Extension of Secondary Payor Status Beyond Age 69	1862(b)(3)(A) (111)	9201(a)(2)	171	3, 28, 83, 86, 89, 130	—	297, 408	490

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Medicare - Agreements with Providers - Peer Review Organization Reimbursement (technical amendment)	1866(a)(1)(F) (ii)	9402(a)(2)	200	—	—	—	—
Medicare - Agreements with Providers - Peer Review Organization Reimbursement - Amounts	1866(a)(1)(F) (iii) Stricken	9402(a)(1)	200	—	—	308	525
Medicare - Agreements with Providers - Peer Review Organization Reimbursement (technical amendment)	1866(a)(1)(F) (iv) Redesi- gnated as (iii)	9402(a)(3)	200	—	—	—	—
Medicare - Agreements with Providers - Peer Review Organization Reimbursement - Amounts	1866(a)(1)(F) (iii) As redesignated	9402(a)(4)	200	—	—	308	525
Medicare - Agreements with Providers - Emergency Medical Conditions and Women in Active Labor (technical amendment)	1866(a)(1)(G)	9121(a)(1)	164	130	1, 11	—	—
Medicare - Agreements with Providers - Denial of Payment for Substandard Care (technical amendment)	1866(a)(1)(G)	9403(b)	200	—	—	—	—
Medicare - Agreements with Providers - Emergency Medical Condition and Women in Active Labor (technical amendment)	1866(a)(1)(H)	9121(a)(2)	164	130	1, 11	—	—
Medicare - Agreements with Providers - Hospital in Champus and Champva Programs	1866(a)(1)(H)	9122(a)(1)	167	—	—	211, 216	396
Medicare - Agreements with Providers - Denial of Payment for Substandard Care (technical amendment)	1866(a)(1)(H)	9403(b)	200	—	—	—	—

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Medicare - Agreements with Providers - Emergency Medical Conditions and Women in Active Labor - Hospital Responsibilities (conforming amendment)	1866(a)(1)(I) New	9121(a)(3)	164	130	1, 11	—	—
Medicare - Agreements with Providers - Hospital Participation in Champus and Champva Programs (technical amendment)	1866(a)(1)(I)	9122(a)(2)	167	—	—	—	—
Medicare - Agreements with Providers - Denial of Payment for Substandard Care - Waiver of Liability	1866(a)(1)(I) second New	9403(b)	200	—	—	—	—
Medicare - Agreements with Providers - Hospital Participation in Champus and Champva Programs	1866(a)(1)(J) New	9122(a)(3)	167	—	—	211, 216	396
Medicare - Agreements with Providers - Waiver Deductibles - Second or Third Opinions	1866(a)(2)(A)	9401(b) second (2)(F)	199	—	—	—	519
Medicare - Emergency Medical Conditions and Women in Active Labor - Hospital Responsibilities	1867 New	9121(b)	164	3, 27, 131	2, 5, 11, 15, 23	460	473
Medicare - Health Maintenance Organizations and Competitive Medical Plans - Prompt Publication of Per Capita Rates	1876(a)(1)(A)	9211(d)	179	4, 31, 134	—	300	493
Medicare - Health Maintenance Organizations and Competitive Medical Plans - Hospitalization on Date of Enrollment or Disenrollment (conforming amendment)	1876(a)(3)	9211(a)(2)	179	134	—	—	—

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Medicare - Health Maintenance Organizations and Competitive Medical Plans - Hospitalization on Date of Enrollment or Disenrollment (conforming amendment)	1876(a)(6)	9211(a)(3)	179	135	--	--	--
Medicare - Health Maintenance Organizations and Competitive Medical Plans - Hospitalization on Date of Disenrollment - Effective Date	1876(c)(3)(B)	9211(b)(1)	179	4, 29, 135	--	--	491
Medicare - Health Maintenance Organizations and Competitive Medical Plans - Hospitalization on Date of Disenrollment - Notice of Claimant	1876(c)(3)(B)	9211(b)(2)	179	4, 30, 135	--	--	492
Medicare - Health Maintenance Organizations and Competitive Medical Plans - Review of Marketing Material by Secretary	1876(c)(3)(C)	9211(c)	179	4, 30, 135	--	--	492
Medicare - Health Maintenance Organizations and Competitive Medical Plans - Hospitalization on Date of Enrollment or Disenrollment - Financial Responsibility	1876(c)(7) New	9211(a)(1)	178	4, 29, 135	--	--	491
Medicare - Inpatient Hospital Services - Return on Equity - Exclusion from Prospective Payment	1886(a)(4)	9107(a)(2)(A)	160	3, 20	--	--	462
Medicare - Inpatient Hospital Services - Return on Equity - Exclusion from Prospective Payment (technical amendment)	1886(a)(4)	9107(a)(2)(B)	160	--	--	--	--
Medicare - Inpatient Hospital Services - Rate of Increase in Payments	1886(b)(3)(B)	9101(b)	153	1, 11, 80, 86, 88, 136	--	289, 408	450

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Medicare - Inpatient Hospital Services - Reimbursement Control System - Four-Year Test for State Waivers	1886(c)(7) New	9109(a)	161	6, 21, 83, 137	—	292	464
Medicare - Inpatient Hospital Services - One-Year Extension of Prospective Payment System Transition	1886(d)(1)(A) (ii)	9102(a)	155	2, 12, 83, 88, 137	—	—	451
Medicare - Inpatient Hospital Services - One-year Extension of Prospective Payment System Transition	1886(d)(1)(A) (iii)	9102(a)	155	2, 12, 83, 88, 137	—	—	451
Medicare - Inpatient Hospital Services - One-Year Extension of Prospective Payment System Transition (technical amendment)	1886(d)(1)(C)	9102(b)(1)	155	138	—	—	—
Medicare - Inpatient Hospital Services - One-Year Extension of Prospective Payment System Transition (technical amendment)	1886(d)(1)(C) (ii)	9102(b)(2)	155	—	—	—	—
Medicare - Inpatient Hospital Services - One-Year Extension of Prospective Payment System Transition - New Percentage	1886(d)(1)(C) (iii) New	9102(b)(4)	155	—	—	—	451
Medicare - Inpatient Hospital Services - One-Year Extension of Prospective Payment System Transitions (technical amendment)	1886(d)(1)(C) (iii) Redesi- gnated as (iv)	9102(b)(3)	155	—	—	—	—
Medicare - Inpatient Hospital Services - One-year Extension of Prospective Payment System Transitions National/Regional Rates	1886(d)(1)(D)	9102(c)(1)	155	2, 12, 83, 88	—	—	451

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Medicare - Inpatient Hospital Services - One-Year Extension of Prospective Payment System Transitions National/Regional Rates	1886(d)(1)(D)	9102(c)(2)	155	2, 12, 83, 88, 138	—	—	451
Medicare - Inpatient Hospital Services - Payments for Indirect Cost of Medical Education - Restandard- izing Amounts	1886(d)(2)(C) (i)	9104(b)(1)	157	2, 14, 81, 83, 89, 138	—	290, 408	455
Medicare - Inpatient Hospital Services - Restandardization of Diagnostic Related Group Payment Amounts - Disproportionate Share Payments (technical amendment)	1886(d)(2)(C) (ii)	9105(b)(1)	159	138	—	—	—
Medicare - Inpatient Hospital Services - Restandardization of Diagnostic Related Group Payment Amounts - Disproportionate Share Payments (technical amendment)	1886(d)(2)(C) (iii)	9105(b)(2)	159	138	—	—	—
Medicare - Inpatient Hospital Services - Restandardizing Diagnostic Related Group Payment Amounts - Disproportionate Share Payments of Low Income Clientele	1886(d)(2)(C) (iv) New	9105(b)(3)	159	2, 15, 83, 89, 139	—	291, 408	458
Medicare - Inpatient Hospital Services - Rate of Increase in Payments (conforming amendment)	1886(d)(3)(A)	9101(c)(1)	154	139	—	—	—
Medicare - Inpatient Hospital Services - Indirect Costs of Medical Education - Savings from Provision Amendment (technical amendment)	1886(d)(3)(C) Redesignated as (C)(i)	9104(b)(2)(A)	157	139	—	—	—

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Medicare - Inpatient Hospital Services - Indirect Costs of Medical Education - Savings from Provision Amendment (technical amendment)	1886(d)(3)(C) (1)	9104(b)(2)(B)	157	139	—	—	—
Medicare - Inpatient Hospital Services - Indirect Costs of Medical Education - Savings from Provision Amendment (technical amendment)	1886(d)(3)(C) (1)	9104(b)(2)(C)	158	139	—	—	—
Medicare - Inpatient Hospital Services - Indirect Costs of Medical Education - Savings from Provision Amendment	1886(d)(3)(C) (1) New	9104(b)(2)(D)	158	2, 14, 81, 89, 139	—	290, 408	456
Medicare - Inpatient Hospital Services - Indirect Costs of Medical Education - Savings from Provision Amendment (conforming amendment)	1886(d)(3)(D) (1)(I)	9104(b)(3)	158	140	—	—	—
Medicare - Inpatient Hospital Services - Indirect Costs of Medical Education - Savings from Provision Amendment (conforming amendment)	1886(d)(3)(D) (1)(I)	9104(b)(3)	158	140	—	—	—
Medicare - Inpatient Hospital Services - Payment for Indirect Costs of Medical Education	1886(d)(5)(B)	9104(a)	157	2, 14, 81, 89, 140	—	290, 408	456
Medicare - Inpatient Hospital Services - Restandardizing Diagnostic Related Group Payment Amounts - Disproportionate Share of Low Income Clientele (conforming amendment)	1886(d)(5)(C) (1)	9105(c)	160	—	—	—	—
Medicare - Inpatient Hospital Services - Treatment of Certain Rural Osteopathic Hospital or Rural Referral Centers	1886(d)(5)(C) (1)	9106(a)	160	6, 19, 83, 141	—	—	462

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Medicare - Inpatient Hospital Services - Adjustment for Additional Facilities in Sole Community Hospitals	1886(d)(5)(C) (11)	9111(a)	162	—	—	—	468
Medicare - Inpatient Hospital Services - Payment to Hospitals with Disproportionate Share of Low Income Clientele	1886(d)(5)(F) New	9105(a)	158	2, 15, 83, 89, 141	—	291, 408	458
Medicare - Inpatient Hospital Services - Rate of Increase in Payments (conforming amendment)	1886(e)(3)	9101(c)(2)	154	—	—	—	—
Medicare - Inpatient Hospital Services - Rate of Increase in Payments (conforming amendment)	1886(e)(4)	9101(c)(3)	154	142	—	—	—
Medicare - Inpatient Hospital Services - Additional Members of Prospective Payment Assessment Commission	1886(e)(6)(A)	9127(a)	170	3, 36, 83, 142	—	307	470
Medicare - Inpatient Hospital Services - Phase-Down of Return on Equity Capital (conforming amendment)	1886(g)(2)	9107(a)(1)(A)	160	144	—	—	—
Medicare - Inpatient Hospital Services - Phase-Down of Return on Equity Capital (technical amendment)	1886(g)(2) Redesignated as (2)(A)	9107(a)(1)(B)	160	—	—	—	—
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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H. Rep. 99-241 Part 1</u>	<u>H. Rep. 99-241 Part 3</u>	<u>S. Rep. 99-146</u>	<u>H.C. Rep. 99-453</u>
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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-241 Part 1</u>	<u>H.Rep. 99-241 Part 3</u>	<u>S.Rep. 99-146</u>	<u>H.C.Rep. 99-453</u>
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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H. Rep. 99-241 Part 1</u>	<u>H. Rep. 99-241 Part 3</u>	<u>S. Rep. 99-146</u>	<u>H. C. Rep. 99-453</u>
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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-241 Part 1</u>	<u>H.Rep. 99-241 Part 3</u>	<u>S.Rep. 99-146</u>	<u>H.C.Rep. 99-453</u>
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<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-241 Part 1</u>	<u>H.Rep. 99-241 Part 3</u>	<u>S.Rep. 99-146</u>	<u>H.C.Re 99-453</u>
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For a narrative account of the legislative history of P.L. 99-272 and a summary of its provisions, see: Social Security Bulletin, August 1986, Vol. 49, No. 8.



PUBLIC LAW 99-272—APR. 7, 1986

**CONSOLIDATED OMNIBUS BUDGET RECON-
CILIATION ACT OF 1985**

Public Law 99-272
99th Congress

An Act

Apr. 7, 1986
[H.R. 3128]

To provide for reconciliation pursuant to section 2 of the first concurrent resolution on the budget for fiscal year 1986 (S. Con. Res. 32, Ninety-ninth Congress).

Consolidated
Omnibus Budget
Reconciliation
Act of 1985.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "Consolidated Omnibus Budget Reconciliation Act of 1985".

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Title I. Agriculture programs.
Title II. Armed services and defense-related programs.
Title III. Housing and community development programs.
Title IV. Transportation and related programs.
Title V. Corporation for Public Broadcasting and Federal Communications Commission.
Title VI. Maritime, coastal zone, and related programs.
Title VII. Energy and related programs.
Title VIII. Outer Continental Shelf and related programs.
Title IX. Medicare, Medicaid, and Maternal and Child Health programs.
Title X. Private health insurance coverage.
Title XI. Single-employer plan termination insurance system amendments.
Title XII. Income security and related programs.
Title XIII. Revenues, trade, and related programs.
Title XIV. Revenue sharing.
Title XV. Civil service, postal service, and governmental affairs generally.
Title XVI. Higher education programs.
Title XVII. Graduate Medical Education Council and technical amendments to the Public Health Service Act.
Title XVIII. Small business programs.
Title XIX. Veterans' programs.
Title XX. Miscellaneous provisions.

TITLE I—AGRICULTURE PROGRAMS

Subtitle A—Agricultural Program Savings

SEC. 1001. AGRICULTURAL PROGRAM SAVINGS.

The expenditures and outlays resulting from the provisions of title XI (relating to the export sales of dairy products) and title XIII (relating to emergency disaster loans and loan authorizations under the Agricultural Credit Insurance Fund) of the Food Security Act of 1985 (H.R. 2100, 99th Congress) shall be counted for purposes of determining savings under the Consolidated Omnibus Budget Reconciliation Act of 1985 as having been enacted under this Act.

(2) The acceptance of any payment by a State under this section shall satisfy and release any and all claims of such State against the United States arising under, or related to, section 8(g) of the Outer Continental Shelf Lands Act, as it was in effect prior to the date of enactment of this Act and shall vest in such State the right to receive payments as set forth in this section.

Claims.

Ante, p. 148.

(c) Notwithstanding any other provision of this Act, the amounts due and payable to the State of Louisiana prior to October 1, 1986, under subtitle A of title VIII (Outer Continental Shelf and Related Programs) of this Act shall remain in their separate accounts in the Treasury of the United States and continue to accrue interest until October 1, 1986, except that the \$572,000,000 set forth in subsection 8004(b)(1)(A) of this section shall only accrue interest from April 15, 1986 to October 1, 1986, at which time the Secretary shall immediately distribute such sums with accrued interest to the State of Louisiana.

Louisiana.

SEC. 8005. IMMOBILIZATION OF BOUNDARIES.

Section 2(b) of the Submerged Lands Act (43 U.S.C. 1301(b)) is amended by inserting before the semicolon at the end a comma and the following: "except that any boundary between a State and the United States under this Act which has been or is hereafter fixed by coordinates under a final decree of the United States Supreme Court shall remain immobilized at the coordinates provided under such decree and shall not be ambulatory".

State and local governments.

TITLE IX—MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

Medicare and Medicaid Budget Reconciliation Amendments of 1985.
42 USC 1305 note.

SEC. 9000. SHORT TITLE; TABLE OF CONTENTS OF TITLE.

This title may be cited as the "Medicare and Medicaid Budget Reconciliation Amendments of 1985".

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- Sec. 9524. Wisconsin health maintenance organization waiver.
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- Sec. 9526. Reference to provisions of law providing coverage under, or directly affecting, the medicaid program.
- Sec. 9527. Children with special health care needs.
- Sec. 9528. Annual calculation of Federal medical assistance percentage.
- Sec. 9529. Medicaid coverage relating to adoption assistance and foster care.

Subtitle C—Task Force on Long-Term Health Care Policies

- Sec. 9601. Recommendations for long-term health care policies.

Subtitle A—Medicare

PART 1—PROVISIONS RELATING TO PART A OF MEDICARE

Subpart A—Hospital Reimbursement

SEC. 9101. RATE OF INCREASE IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES.

(a) EXTENSION OF CURRENT FREEZE ON PAYMENT RATES THROUGH APRIL 30, 1986.—Section 5(c) of the Emergency Extension Act of 1985 (Public Law 99-107) is amended to read as follows:

“(c) EXTENSION PERIOD DEFINED.—

42 USC 1395ww
note.

“(1) HOSPITAL PAYMENTS.—For purposes of subsection (a), the term ‘extension period’ means the period beginning on October 1, 1985, and ending on April 30, 1986.”

(b) APPLICABLE PERCENTAGE INCREASE.—Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended to read as follows:

“(B)(i) For purposes of subparagraph (A) for 12-month cost reporting periods beginning during a fiscal year and for purposes of subsection (d) for discharges occurring during a fiscal year, the ‘applicable percentage increase’ shall be—

“(I) for fiscal year 1986, ½ percent,

“(II) for fiscal years 1987 and 1988, a percentage determined by the Secretary pursuant to subsection (e)(4), but not to exceed the market basket percentage increase (as defined in clause (ii)), and

“(III) for fiscal year 1989 and subsequent fiscal years, the percentage determined by the Secretary pursuant to subsection (e)(4).

“(ii) For purposes of clause (i), the term ‘market basket percentage increase’ means, with respect to cost reporting periods and discharges occurring in a fiscal year, the percentage, estimated by the Secretary before the beginning of the period or fiscal year, by which the cost of the mix of goods and services (including personnel costs but excluding nonoperating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for the period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year.”.

(c) **CONFORMING AMENDMENTS.**—(1) Section 1886(d)(3)(A) of such Act (42 U.S.C. 1395ww(d)(3)(A)) is amended by striking out “for fiscal year 1985” and inserting in lieu thereof “for each of fiscal years 1985 and 1986”.

(2) Section 1886(e)(3) of such Act is amended by striking out “(instead of the applicable percentage increase described in subsection (b)(3)(B))”.

(3) Section 1886(e)(4) of such Act is amended by striking out “1986” and inserting in lieu thereof “1987”.

(d) **EFFECTIVE DATE OF FREEZE EXTENSION.**—The amendment made by subsection (a) shall take effect on March 15, 1986, and the amendments made by subsection (c) shall take effect on the date of the enactment of this Act.

(e) **EFFECTIVE DATE FOR INCREASE.**—

(1) **PPS HOSPITALS, DRG PORTION OF PAYMENT.**—In the case of a subsection (d) hospital (as defined in paragraph (4))—

(A) the amendment made by subsection (b) shall apply to payments made under section 1886(d)(1)(A) of such Act made on the basis of discharges occurring on or after May 1, 1986; and

(B) for discharges occurring on or after October 1, 1986, the applicable percentage increase (described in section 1886(b)(3)(B)) for discharges occurring during fiscal year 1986 shall be deemed to have been $\frac{1}{2}$ percent.

(2) **PPS HOSPITALS, HOSPITAL SPECIFIC PORTION OF PAYMENT.**—In the case of a subsection (d) hospital—

(A) the amendment made by subsection (b) shall apply to payments under section 1886(d)(1)(A) of the Social Security Act made on the basis of discharges occurring during a cost reporting period of a hospital, for the hospital’s cost reporting periods beginning on or after October 1, 1985;

(B) notwithstanding subparagraph (A), for the cost reporting period beginning during fiscal year 1986, the applicable percentage increase (as defined in section 1886(b)(3)(B) of such Act) for the—

(i) first 7 months of the cost reporting period shall be 0 percent, and

(ii) for the remaining 5 months of the cost reporting period shall be $\frac{1}{2}$ percent; and

(C) for cost reporting periods beginning on or after October 1, 1986, the applicable percentage increase (as so

42 USC 1395ww
note.

42 USC 1395ww
note.

defined) with respect to the previous cost reporting period shall be deemed to have been $\frac{1}{2}$ percent.

(3) PPS-EXEMPT HOSPITALS.—In the case of a hospital that is not a subsection (d) hospital—

(A) the amendment made by subsection (b) shall apply to cost reporting periods beginning on or after October 1, 1985;

(B) notwithstanding subparagraph (A), for the hospital's cost reporting period beginning during fiscal year 1986, payment under title XVIII of the Social Security Act shall be made as though the applicable percentage increase described in section 1886(b)(3)(B) were equal to $\frac{5}{24}$ of 1 percent; and

42 USC 1395c.

42 USC 1395www.

(C) for cost reporting periods beginning on or after October 1, 1986, the applicable percentage increase (as so defined) with respect to the cost reporting period beginning during fiscal year 1986 shall be deemed to have been $\frac{1}{2}$ percent.

(4) DEFINITION.—In this subsection, the term “subsection (d) hospital” has the meaning given such term in section 1886(d)(1)(B) of the Social Security Act.

SEC. 9102. ONE-YEAR EXTENSION OF PPS TRANSITION.

(a) ONE-YEAR DELAY OF FULL IMPLEMENTATION OF PROSPECTIVE PAYMENT SYSTEM.—Section 1886(d)(1)(A) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(A)) is amended by striking out “1986” in clauses (ii) and (iii) and inserting in lieu thereof “1987”.

(b) NEW TARGET AND DRG PERCENTAGES FOR REMAINDER OF FISCAL YEAR 1986.—Section 1886(d)(1)(C) of such Act is amended—

(1) by striking out “, or discharges occurring”,

(2) by striking out “and” at the end of clause (ii),

(3) by striking out “(iii) on or after October 1, 1985, and before October 1, 1986” in clause (iii) and inserting in lieu thereof “(iv) on or after October 1, 1986, and before October 1, 1987”, and

(4) by inserting after clause (ii) the following new clause: “(iii) on or after October 1, 1985, and before October 1, 1986, the ‘target percentage’ is 45 percent and the ‘DRG percentage’ is 55 percent; and”.

(c) NEW BLENDED NATIONAL-REGIONAL DRG RATE FOR REMAINDER OF FISCAL YEAR 1986.—Section 1886(d)(1)(D) of such Act is amended—

(1) by striking out “cost reporting periods beginning, or”, and

(2) by striking out “1985” and “1986” and inserting in lieu thereof “1986” and “1987”, respectively, each place it appears.

(d) EFFECTIVE DATES.—

42 USC 1395www
note.

(1) DELAY IN FINAL TRANSITION.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) CHANGE IN HOSPITAL SPECIFIC PERCENTAGE.—The amendments made by subsection (b) shall apply—

(A) to cost reporting periods beginning on or after October 1, 1985, but

(B) notwithstanding subparagraph (A), for a hospital's cost reporting period beginning during fiscal year 1986, for purposes of section 1886(d)(1)(A) of the Social Security Act—

(i) during the first 7 months of the period the “target percentage” is 50 percent and the “DRG percentage” is 50 percent, and

(ii) during the remaining 5 months of the period the "target percentage" is 45 percent and the "DRG percentage" is 55 percent.

(3) **CHANGE IN BLENDED RATE.**—The amendments made by subsection (c) shall apply to discharges occurring on or after May 1, 1986.

(4) **EXCEPTION.**—

Prohibition.

(A) Notwithstanding any other provision of this subsection, the amendments made by this section shall not apply to payments with respect to the operating costs of inpatient hospital services (as defined in section 1886(a)(4) of the Social Security Act) of a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act) located in the State of Oregon.

42 USC 1395ww.

(B) Notwithstanding any other provision of law, for a cost reporting period beginning during fiscal year 1986 of a subsection (d) hospital to which the amendments made by this section do not apply, for purposes of section 1886(d)(1)(A) of of Social Security Act—

(i) during the first 7 months of the period the "target percentage" is 50 percent and the "DRG percentage" is 50 percent, and

(ii) during the remaining 5 months of the period the "target percentage" is 25 percent and the "DRG percentage" is 75 percent.

(C) Notwithstanding any other provision of law, for purposes of section 1886(d)(1)(D) of such Act, the applicable combined adjusted DRG prospective payment rate for a subsection (d) hospital to which the amendments made by this section do not apply is, for discharges occurring on or after October 1, 1985, and before May 1, 1986, a combined rate consisting of 25 percent of the national adjusted DRG prospective payment rate and 75 percent of the regional adjusted DRG prospective payment rate for such discharges.

SEC. 9103. APPLICATION OF REVISED HOSPITAL WAGE INDEX.

42 USC 1395ww
note.

(a) **APPLICATION OF REVISED INDEX PROSPECTIVELY.**—(1) Section 2316(b) of the Deficit Reduction Act of 1984 (98 Stat. 1081) is amended to read as follows:

"(b) The Secretary shall adjust the payment amounts for hospitals for discharges occurring on or after May 1, 1986, to reflect the changes the Secretary has promulgated in final regulations (on September 3, 1985) relating to the hospital wage index under section 1886(d)(3)(E) of the Social Security Act. For discharges occurring after September 30, 1986, the Secretary shall provide for such periodic adjustments in the appropriate wage index used under that section as may be necessary, taking into account changes in the wage levels and relative proportions of full-time and part-time workers."

42 USC 1395ww
note.
26 USC 1 note.
42 USC 1395ww
note.

(2) The amendment made by paragraph (1) shall be effective as if it had been included in the Deficit Reduction Act of 1984.

(b) **STUDY OF METHODOLOGY FOR AREA WAGE ADJUSTMENT FOR CENTRAL CITIES.**—(1) The Secretary of Health and Human Services, in consultation with the Prospective Payment Assessment Commission, shall collect information and shall develop one or more methodologies to permit the adjustment of the wage indices used for

purposes of sections 1886(d)(2)(C)(ii), 1886(d)(2)(H), and 1886(d)(3)(E) of the Social Security Act, in order to more accurately reflect hospital labor markets, by taking into account variations in wages and wage-related costs between the central city portion of urban areas and other parts of urban areas.

42 USC 1395ww.

(2) The Secretary shall report to Congress on the information collected and the methodologies developed under paragraph (1) not later than May 1, 1987. The report shall include a recommendation as to the feasibility and desirability of implementing such methodologies.

Report.

SEC. 9104. PAYMENTS TO HOSPITALS FOR INDIRECT COSTS OF MEDICAL EDUCATION.

(a) **PAYMENT FOR INDIRECT COSTS OF MEDICAL EDUCATION.**—Section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)) is amended to read as follows:

“(B) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:

“(i) The amount of such additional payment shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and the amount paid to the hospital under subparagraph (A), by (II) the indirect teaching adjustment factor described in clause (ii).

“(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor for discharges occurring—

“(I) on or after May 1, 1986, and before October 1, 1988, is equal to $2 \times ((1+r)^{405} - 1)$, or

“(II) on or after October 1, 1988, is equal to $1.5 \times ((1+r)^{5795} - 1)$,

where ‘r’ is the ratio of the hospital’s full-time equivalent interns and residents to beds.

“(iii) In determining such adjustment the Secretary shall not distinguish between those interns and residents who are employees of a hospital and those interns and residents who furnish services to a hospital but are not employees of such hospital.

“(iv) In determining such adjustment, the Secretary shall continue to count interns and residents assigned to outpatient services of the hospital as part of the calculation of the full-time-equivalent number of interns and residents.”.

(b) **ADJUSTMENT OF PAYMENT AMOUNTS.**—

(1) **RE STANDARDIZING DRG PAYMENT AMOUNTS TO REFLECT CHANGE IN FORMULA.**—Section 1886(d)(2)(C)(i) of such Act is amended by inserting “(taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconciliation Amendments of 1985)” after “medical education costs”.

(2) **PROVIDING FOR SYSTEM SAVINGS FROM CHANGE IN FORMULA.**—Subparagraph (C) of section 1886(d)(3) of such Act is amended—

(A) by inserting “(i)” after “(C)”,

(B) by inserting “FOR FISCAL YEAR 1985” after “NEUTRALITY”,

(C) by striking out "The Secretary" and inserting in lieu thereof "For discharges occurring in fiscal year 1985, the Secretary", and

(D) by adding at the end the following new clause:

"(ii) REDUCING FOR SAVINGS FROM AMENDMENT TO INDIRECT TEACHING ADJUSTMENT FOR DISCHARGES AFTER SEPTEMBER 30, 1986.—For discharges occurring after September 30, 1986, the Secretary shall further reduce each of the average standardized amounts (in a proportion which takes into account the differing effects of the standardization effected under paragraph (2)(C)(i)) so as to provide for a reduction in the total of the payments (attributable to this paragraph) made for discharges occurring—

"(I) on or after October 1, 1986, and before October 1, 1988, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985 if the factor described in clause (ii)(II) of paragraph (5)(B) were applied for discharges occurring during such period instead of the factor described in clause (ii)(I) of that paragraph, and

"(II) on or after October 1, 1988, of an amount equal to the estimated reduction in the payment amounts under paragraph (5)(B) for those discharges that has resulted from the enactment of the amendments made by section 9104 of the Medicare and Medicaid Budget Reconciliation Amendments of 1985."

(3) CONFORMING AMENDMENT.—Clauses (i)(I) and (ii)(I) of section 1886(d)(3)(D) of such Act are each amended by inserting "or reduced" after "(B), and adjusted".

(c) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), the amendments made by this section shall apply to discharges occurring on or after May 1, 1986.

(2) The amendments made by this section shall not first be applied to discharges occurring as of a date unless, for discharges occurring on that date, the amendments made by section 9105 are also being applied.

SEC. 9105. PAYMENTS FOR HOSPITALS WHICH SERVE A DISPROPORTIONATE SHARE OF LOW-INCOME PATIENTS.

(a) PAYMENT FOR HOSPITALS WHICH SERVE A DISPROPORTIONATE SHARE OF LOW-INCOME PATIENTS.—Section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)) is amended by adding at the end the following new subparagraph:

"(F)(i) For discharges occurring on or after May 1, 1986, and before October 1, 1988, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—

"(I) serves a significantly disproportionate number of low-income patients (as defined in clause (v)), or

"(II) is located in an urban area, has 100 or more beds, and can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this title or State plans approved under title XIX), during the cost reporting period in which the discharges occur, for indigent care from State and local government sources exceed 30 percent of its total of such revenues during the period.

42 USC 1395ww.

42 USC 1395ww
note.

Urban areas.
State and local
governments.

“(ii) The amount of such payment for each discharge shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and the amount paid to the hospital under subparagraph (A) for that discharge, by (II) the disproportionate share adjustment percentage established under clause (iii) or (iv) for the cost reporting period in which the discharge occurs.

“(iii) The disproportionate share adjustment percentage for a cost reporting period for a hospital described in clause (i)(II) is equal to 15 percent.

Rural areas.

“(iv) The disproportionate share adjustment percentage for a cost reporting period for a hospital that is not described in clause (i)(II) and that—

“(I) is located in an urban area and has 100 or more beds, is equal to the lesser of 15 percent, or the percent determined in accordance with the following formula: $(P - 15) \times .5 + 2.5$, where ‘P’ is the hospital’s disproportionate patient percentage (as defined in clause (vi));

“(II) is located in an urban area and has less than 100 beds, is equal to 5 percent; or

“(III) is located in a rural area, is equal to 4 percent.

“(v) In this subparagraph, a hospital ‘serves a significantly disproportionate number of low income patients’ for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals, or exceeds—

Rural areas.

“(I) 15 percent, if the hospital is located in an urban area and has 100 or more beds,

“(II) 40 percent, if the hospital is located in an urban area and has less than 100 beds, or

“(III) 45 percent, if the hospital is located in a rural area.

“(vi) In this subparagraph, the term ‘disproportionate patient percentage’ means, with respect to a cost reporting period of a hospital, the sum of—

“(I) the fraction (expressed as a percentage), the numerator of which is the number of such hospital’s patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this title and were entitled to supplementary security income benefits (excluding any State supplementation) under title XVI of this Act, and the denominator of which is the number of such hospital’s patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this title, and

“(II) the fraction (expressed as a percentage), the numerator of which is the number of the hospital’s patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, but who were not entitled to benefits under part A of this title, and the denominator of which is the total number of the hospital’s patient days for such period.”

(b) **RE STANDARDIZING DRG PAYMENT AMOUNTS TO REFLECT DISPROPORTIONATE SHARE PAYMENTS.**—Section 1886(d)(2)(C) of such Act is amended—

42 USC 1395ww.

(1) by striking out “and” at the end of clause (ii),

(2) by striking out the period at the end of clause (iii) and inserting in lieu thereof “, and”, and

(3) by adding at the end the following new clause:

“(iv) for discharges occurring on or after October 1, 1986, and before October 1, 1988, excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F).”.

42 USC 1395ww.

(c) **CONFORMING AMENDMENT.**—Section 1886(d)(5)(C)(i) of such Act is amended by striking out “, and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this title”.

(d) **CBO REPORT.**—The Congressional Budget Office shall study, and report to Congress not later than January 1, 1987, on the impact of the implementation of this section on hospitals, including the appropriateness of the factors used in determining which hospitals are eligible for additional payments under section 1886(d)(5)(F) of the Social Security Act and the amount of the additional payments made to those hospitals.

42 USC 1395ww.

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply to discharges occurring on or after May 1, 1986.

SEC. 9106. TREATMENT OF CERTAIN RURAL OSTEOPATHIC HOSPITALS AS RURAL REFERRAL CENTERS.

(a) **IN GENERAL.**—Section 1886(d)(5)(C)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(C)(i)) is amended by inserting before the period at the end of the second sentence the following: “and which shall not require a rural osteopathic hospital to have more than 3,000 discharges in a year in order to be classified as a rural referral center”.

42 USC 1395ww
note.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to cost reporting periods beginning on or after January 1, 1986.

SEC. 9107. RETURN ON EQUITY CAPITAL FOR INPATIENT HOSPITAL SERVICES AND OTHER SERVICES.

(a) **INPATIENT HOSPITAL SERVICES.**—

(1) **PHASE-DOWN IN PAYMENT FOR RETURN ON EQUITY CAPITAL.**—Section 1886(g)(2) of the Social Security Act (42 U.S.C. 1395ww(g)(2)) is amended—

(A) by inserting “the applicable percentage (described in subparagraph (B)) of” before “the average of the rates of interest”,

(B) by inserting “(A)” after “(2)”, and

(C) by adding at the end the following new subparagraph:

“(B) In this paragraph, the ‘applicable percentage’ is—

“(i) 75 percent, for cost reporting periods beginning during fiscal year 1987,

“(ii) 50 percent, for cost reporting periods beginning during fiscal year 1988,

“(iii) 25 percent, for cost reporting periods beginning during fiscal year 1989, and

“(iv) 0 percent, for cost reporting periods beginning on or after October 1, 1989.”.

(2) **EXCLUSION FROM PROSPECTIVE PAYMENT.**—The second sentence of section 1886(a)(4) of such Act is amended—

(A) by inserting “a return on equity capital,” after “anesthetist,”, and

(B) by inserting “other” before “capital-related costs”.

(b) **OTHER SERVICES.**—

(1) **LIMITATION ON RATE.**—Section 1861(v)(1) of such Act (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

“(P) If such regulations provide for the payment for a return on equity capital (other than with respect to costs of inpatient hospital services), the rate of return to be recognized, for determining the reasonable cost of services furnished in a cost reporting period, shall be equal to the average of the rates of interest, for each of the months any part of which is included in the period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.”.

(2) **CONFORMING AMENDMENTS.**—Section 1861(v)(1)(B) of such Act is amended—

(A) by striking out “any fiscal period” and “such fiscal period” and inserting in lieu thereof “any cost reporting period” and “the period”, respectively, and

(B) by striking out “not exceed one and one-half times” in the second sentence and inserting in lieu thereof “be equal to”.

(c) **EFFECTIVE DATES.**—(1) The amendments made by subsection (a) shall apply to hospital cost reporting periods beginning on or after October 1, 1986.

42 USC 1395ww
note.

(2) The amendments made by subsection (b) shall apply to cost reporting periods beginning on or after October 1, 1985.

42 USC 1395x
note.

SEC. 9108. CONTINUATION OF MEDICARE REIMBURSEMENT WAIVERS FOR CERTAIN HOSPITALS PARTICIPATING IN REGIONAL HOSPITAL REIMBURSEMENT DEMONSTRATIONS.

(a) **CONTINUATION OF WAIVERS.**—A hospital reimbursement control system which, on January 1, 1985, was carrying out a demonstration under a contract which had been approved by the Secretary of Health and Human Services pursuant to section 222(a) of the Social Security Amendments of 1972, or under section 402 of the Social Security Amendments of 1967 (as amended by section 222(b) of the Social Security Amendments of 1972), shall be deemed to meet the requirements of section 1886(c)(1)(A) of the Social Security Act if such system applies—

42 USC 1395ww
note.

(1) to substantially all non-Federal acute care hospitals (as defined by the Secretary) in the geographic area served by such system on January 1, 1985, and

42 USC 1395b-1
note.

(2) to the review of at least 75 percent of—

(A) all revenues or expenses in such geographic area for inpatient hospital services, and

(B) revenues or expenses in such geographic area for inpatient hospital services provided under the State's plan approved under title XIX.

Infra.

(b) **APPROVAL.**—In the case of a hospital cost control system described in subsection (a), the requirements of section 1886(c) of the Social Security Act which apply to States shall instead apply to such system and, for such purposes, any reference to a State is deemed a reference to such system.

(c) **EFFECTIVE DATE.**—This section shall become effective on the date of the enactment of this Act.

SEC. 9109. FOUR-YEAR TEST FOR STATE WAIVERS FOR CERTAIN STATES.

(a) **IN GENERAL.**—Section 1886(c) of the Social Security Act (42 U.S.C. 1395ww(c)) is amended by adding at the end the following new paragraph:

Prohibition.

“(7) In the case of a State which made a request under paragraph (5) before December 31, 1984, for the approval of a State hospital reimbursement control system and which request was approved—

“(A) in applying paragraphs (1)(C) and (6), a reference to a ‘36-month period’ is deemed a reference to a ‘48-month period’, and

“(B) in order to allow the State the opportunity to provide the assurances described in paragraph (1)(C) for a 48-month period, the Secretary may not discontinue payments under the system, under the authority of paragraph (3)(A) because the Secretary has reason to believe that such assurances are not being (or will not be) met, before July 1, 1986.”.

42 USC 1395ww
note.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 9110. ASSET VALUATION FOR DONATIONS OF STATE PROPERTY TO NONPROFIT CORPORATIONS.

(a) **GENERAL RULE.**—Section 1861(v)(1)(O) of the Social Security Act (42 U.S.C. 1395x(v)(1)(O)) is amended—

(1) by inserting “, except as provided in clause (iv),” in clause

(i) after “such regulations shall provide”, and

(2) by adding at the end the following new clause:

“(iv) In the case of the transfer of a hospital from ownership by a State to ownership by a nonprofit corporation without monetary consideration, the basis for capital allowances to the new owner shall be the book value of the hospital to the State at the time of the transfer.”.

42 USC 1395x
note.
26 USC 1 note.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall be applied as though they were originally included in the Deficit Reduction Act of 1984.

SEC. 9111. PAYMENTS TO SOLE COMMUNITY HOSPITALS.

(a) **ADJUSTMENT TO PAYMENT AMOUNT.**—Section 1886(d)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(C)(ii)) is amended by inserting after the second sentence thereof the following: “In the case of a sole community hospital which experiences, in any cost reporting period after the cost reporting period which was used as the base for determining the target amount for payments to such hospital under paragraph (1)(A)(i)(I), a significant increase in operating costs attributable to the addition of new inpatient facilities or services at such hospital (including the opening of a special care unit), the Secretary shall provide for such adjustment to the payment amounts under this subsection for such cost reporting period and subsequent cost reporting periods as may be necessary to reasonably compensate such hospital for such increased costs.”.

42 USC 1395ww
note.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall apply to payments for cost reporting periods beginning on or after October 1, 1983, and before October 1, 1989.

(c) **STUDY.**—The Secretary of Health and Human Services shall conduct a study of the effects of the amendment made by subsection (a). The Secretary shall report the results of such study, including recommendations for a permanent mechanism to take into account needed expansions of services by sole community hospitals and the hospital-specific medicare payment rates thereof, to the Congress prior to January 1, 1987.

SEC. 9112. INDIRECT TEACHING ADJUSTMENT FOR CERTAIN CLINICS.

(a) **IN GENERAL.**—Section 602(k) of the Social Security Amendments of 1983 (97 Stat. 165) is amended by inserting “(1)” after “(k)” and by adding at the end the following new paragraphs:

42 USC 1495y
note.

“(2) In the case of a hospital which is receiving payments pursuant to a waiver under paragraph (1), payment of the adjustment for indirect costs of approved educational activities shall be made as if the hospital were receiving under part A of title XVIII of the Social Security Act all the payments which are made under part B of such title solely by reason of such waiver.

42 USC 1395c,
1395j.

“(3) Any waiver granted under paragraph (1) shall provide that, with respect to those items and services billed under part B of title XVIII of the Social Security Act solely by reason of such waiver—

“(A) payment under such part shall be equal to 100 percent of the reasonable charge or other applicable payment base for the items and services; and

“(B) the entity furnishing the items and services must agree to accept the amount paid pursuant to subparagraph (A) as the full charge for the items and services.”.

(b) **EFFECTIVE DATES.**—(1) Section 602(k)(2) of the Social Security Amendments of 1983 (as added by subsection (a)) shall apply to cost reporting periods beginning on or after January 1, 1986.

42 USC 1395y
note.

(2) Section 602(k)(3) of the Social Security Amendments of 1983 (as added by subsection (a)) shall apply to items and services furnished after the end of the 10-day period beginning on the date of the enactment of this Act.

SEC. 9113. REPORT ON IMPACT OF OUTLIER AND TRANSFER POLICY ON RURAL HOSPITALS.

(a) **REVIEW.**—The Secretary of Health and Human Services shall review the impact of policies respecting outliers and patient transfers on payments under section 1886(d) of the Social Security Act to rural hospitals (particularly on rural hospitals with less than 100 beds).

42 USC 1395ww.

(b) **REPORT.**—The Secretary shall report to Congress on the findings of the review not later than January 1, 1987, and shall include in the report recommendations on changes in policies respecting outliers and patient transfers to the extent they adversely affect rural hospitals.

SEC. 9114. INFORMATION ON IMPACT OF PPS PAYMENTS ON HOSPITALS.

(a) **DISCLOSURE OF INFORMATION.**—The Secretary of Health and Human Services shall make available to the Prospective Payment Assessment Commission, the Congressional Budget Office, the Comptroller General, and the Congressional Research Service the most current information on the payments being made under section 1886 of the Social Security Act to individual hospitals. Such information shall be made available in a manner that permits examination of the impact of such section on hospitals.

42 USC 1395ww
note.

(b) **CONFIDENTIALITY.**—Information disclosed under subsection (a) shall be treated as confidential and shall not be subject to further disclosure in a manner that permits the identification of individual hospitals.

SEC. 9115. SPECIAL RULES FOR IMPLEMENTATION OF SUBPART.

(a) **WAIVER OF PAPERWORK REDUCTION.**—Chapter 35 of title 44, United States Code, shall not apply to information required for

42 USC 1395ww
note.
44 USC 3501 *et*
seq.

purposes of carrying out this subpart and implementing the amendments made by this subpart.

(b) **USE OF INTERIM FINAL REGULATIONS.**—The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this subpart and the amendments made by this subpart.

Subpart B—Miscellaneous Provisions

SEC. 9121. RESPONSIBILITIES OF MEDICARE HOSPITALS IN EMERGENCY CASES.

(a) **REQUIREMENT OF MEDICARE HOSPITAL PROVIDER AGREEMENTS.**—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

- (1) by striking out “and” at the end of subparagraph (G),
- (2) by striking out the period at the end of subparagraph (H) and inserting in lieu thereof “, and”, and
- (3) by inserting after subparagraph (H) the following new subparagraph:

Infra. “(I) in the case of a hospital, to comply with the requirements of section 1867 to the extent applicable.”.

(b) **REQUIREMENTS.**—Title XVIII of such Act is amended by inserting after section 1866 the following new section:

“EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN ACTIVE LABOR

42 USC 1395dd.

“SEC. 1867. (a) **MEDICAL SCREENING REQUIREMENT.**—In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists or to determine if the individual is in active labor (within the meaning of subsection (e)(2)).

“(b) **NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND ACTIVE LABOR.**—

“(1) **IN GENERAL.**—If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either—

“(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, or

“(B) for transfer of the individual to another medical facility in accordance with subsection (c).

“(2) **REFUSAL TO CONSENT TO TREATMENT.**—A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the examination or treatment.

“(3) REFUSAL TO CONSENT TO TRANSFER.—A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) but the individual (or a legally responsible person acting on the individual’s behalf) refuses to consent to the transfer.

“(c) RESTRICTING TRANSFERS UNTIL PATIENT STABILIZED.—

“(1) RULE.—If a patient at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(4)(B)) or is in active labor, the hospital may not transfer the patient unless—

“(A)(i) the patient (or a legally responsible person acting on the patient’s behalf) requests that the transfer be effected, or

“(ii) a physician (within the meaning of section 1861(r)(1)), or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual’s medical condition from effecting the transfer; and

42 USC 1395x.

“(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

“(2) APPROPRIATE TRANSFER.—An appropriate transfer to a medical facility is a transfer—

“(A) in which the receiving facility—

“(i) has available space and qualified personnel for the treatment of the patient, and

“(ii) has agreed to accept transfer of the patient and to provide appropriate medical treatment;

“(B) in which the transferring hospital provides the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital;

“(C) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

“(D) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of patients transferred.

“(d) ENFORCEMENT.—

“(1) AS REQUIREMENT OF MEDICARE PROVIDER AGREEMENT.—If a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, such hospital is subject to—

“(A) termination of its provider agreement under this title in accordance with section 1866(b), or

42 USC 1395cc.

“(B) at the option of the Secretary, suspension of such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public.

“(2) CIVIL MONETARY PENALTIES.—In addition to the other grounds for imposition of a civil money penalty under section 1128A(a), a participating hospital that knowingly violates a

42 USC
1320a-7a.

requirement of this section and the responsible physician in the hospital with respect to such a violation are each subject, under that section, to a civil money penalty of not more than \$25,000 for each such violation. As used in the previous sentence, the term 'responsible physician' means, with respect to a hospital's violation of a requirement of this section, a physician who—

"(A) is employed by, or under contract with, the participating hospital, and

"(B) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.

"(3) CIVIL ENFORCEMENT.—

"(A) PERSONAL HARM.—Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

"(B) FINANCIAL LOSS TO OTHER MEDICAL FACILITY.—Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

"(C) LIMITATIONS ON ACTIONS.—No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

"(e) DEFINITIONS.—In this section:

"(1) The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

"(A) placing the patient's health in serious jeopardy,

"(B) serious impairment to bodily functions, or

"(C) serious dysfunction of any bodily organ or part.

"(2) The term 'active labor' means labor at a time at which—

"(A) delivery is imminent,

"(B) there is inadequate time to effect safe transfer to another hospital prior to delivery, or

"(C) a transfer may pose a threat of the health and safety of the patient or the unborn child.

"(3) The term 'participating hospital' means hospital that has entered into a provider agreement under section 1866 and has, under the agreement, obligated itself to comply with the requirements of this section.

"(4)(A) The term 'to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

State and local
governments.

“(B) The term ‘stabilized’ means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a facility.

“(5) The term ‘transfer’ means the movement (including the discharge) of a patient outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

“(f) **PREEMPTION.**—The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.”.

State and local governments.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on the first day of the first month that begins at least 90 days after the date of the enactment of this Act.

42 USC 1395dd note.

(d) **REPORT.**—The Secretary of Health and Human Services shall, not later than 6 months after the effective date described in subsection (c), report to Congress on the methods to be used for monitoring and enforcing compliance with section 1867 of the Social Security Act.

Ante, p. 164.

SEC. 9122. REQUIREMENT FOR MEDICARE HOSPITALS TO PARTICIPATE IN CHAMPUS AND CHAMPVA PROGRAMS.

(a) **IN GENERAL.**—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

Ante, p. 164.

(1) by striking out “and” at the end of subparagraph (H),

(2) by striking out the period at the end of subparagraph (I) and inserting in lieu thereof “, and”, and

(3) by inserting after subparagraph (I) the following new subparagraph:

“(J) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of title 10, or under section 613 of title 38, United States Code, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of title 10, United States Code.”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to agreements entered into or renewed on or after the date of the enactment of this Act, but shall apply only to inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

42 USC 1395cc note.

(c) **REFERENCE TO STUDY REQUIRED.**—For a study of the use by CHAMPUS of the medicare prospective payment system, see section 634 of the Department of Defense Authorization Act, 1985 (Public Law 98-525), the deadline for which is extended under section 2002 of this Act.

98 Stat. 2544.

(d) **REPORT.**—The Secretary of Health and Human Services shall report to Congress periodically on the number of hospitals that have terminated or failed to renew an agreement under section 1866 of the Social Security Act as a result of the additional conditions imposed under the amendments made by subsection (a).

42 USC 1395cc note.

SEC. 9123. EXTENSION AND PAYMENT FOR HOSPICE CARE.

42 USC 1395c
note.

(a) **ELIMINATION OF SUNSET.**—Section 122(h)(1) of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248, 96 Stat. 362), relating to the end of the effective date for hospice care, is amended—

(1) in subparagraph (A)—

(A) by striking out “(h)(1)(A) Subject to subparagraph (B), the” and inserting in lieu thereof “(h)(1) The”, and

(B) by striking out “, and before October 1, 1986”, and

(2) by striking out subparagraph (B).

(b) **INCREASE IN PAYMENT OF DAILY RATES FOR HOSPICE CARE.**—(1) Subparagraph (B) of section 1814(i)(1) of the Social Security Act (42 U.S.C. 1395f(i)(1)) is amended to read as follows:

“(B) Notwithstanding subparagraph (A), for hospice care furnished on or after April 1, 1986, the daily rate of payment per day for routine home care shall be \$63.17 and the daily rate of payment for other services included in hospice care shall be the daily rate of payment recognized under subparagraph (A) as of July 1, 1985, increased by \$10.”

(2) Subparagraph (C) of such section is amended by striking out “1985” and inserting in lieu thereof “1986”.

SEC. 9124. LIMITING THE PENALTY FOR LATE ENROLLMENT IN PART A.

(a) **LIMITING PENALTY TO 10 PERCENT AND TWICE THE PERIOD DURING WHICH NOT ENROLLED.**—Section 1818(c) of the Social Security Act (42 U.S.C. 1395i-2(c)) is amended—

(1) by striking out “and” at the end of paragraph (5),

(2) by striking out the period at the end of paragraph (6) and inserting in lieu thereof “; and”, and

(3) by adding at the end the following new paragraph:

“(7) any percent increase effected under section 1839(b) in an individual’s monthly premium may not exceed 10 percent and shall only apply to premiums paid during a period equal to twice the number of months in the full 12-month periods described in that section.”

42 USC 1395.

42 USC 1395i-2
note.

(b) **EFFECTIVE DATE.**—(1) The amendment made by subsection (a)(3) shall apply to premiums paid for months beginning with July 1986.

(2) In applying that amendment, months (before, during, or after April 1986) in which an individual was required to pay a premium increased under the section that was so amended shall be taken into account in determining the month in which the premium will no longer be subject to an increase under that section as so amended.

SEC. 9125. PROMULGATION OF INPATIENT HOSPITAL DEDUCTIBLE.

(a) **CHANGE IN DEADLINE.**—Section 1813(b)(2) of the Social Security Act (42 U.S.C. 1395e(b)(2)) is amended by striking out “October 1” and inserting in lieu thereof “September 15”.

42 USC 1395e
note.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall apply to calendar years after 1985.

SEC. 9126. ACCESS TO SKILLED NURSING FACILITIES.

(a) **OPTIONAL PROSPECTIVE RATES FOR CERTAIN SKILLED NURSING FACILITIES.**—Section 1888 of the Social Security Act (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

“(d)(1) Any skilled nursing facility may choose to be paid under this subsection on the basis of a prospective payment for all routine service costs (and capital-related costs) of extended care services provided in a fiscal year if such facility had, in the preceding fiscal year, fewer than 1,500 patient days with respect to which payments were made under this title. Such prospective payment shall be in lieu of payments which would otherwise be made for routine service costs pursuant to section 1861(v) and subsections (a) through (c) of this section and capital-related costs pursuant to section 1861(v). This subsection shall not apply to a facility for any fiscal year immediately following a fiscal year in which such facility had 1,500 or more patient days with respect to which payments were made under this title, without regard to whether payments were made under this subsection during such preceding fiscal year.

42 USC 1395x.

Prohibition.

“(2)(A) The amount of the payment under this section shall be determined on a per diem basis.

“(B) Subject to the limitations of subparagraph (C), for skilled nursing facilities located—

Urban areas.
Rural areas.

“(i) in an urban area, the amount shall be equal to 105 percent of the mean of the per diem reasonable routine service and capital-related costs of extended care services for skilled nursing facilities in urban areas within the same region, determined without regard to the limitations of subsection (a) and adjusted for different area wage levels, and

“(ii) in a rural area the amount shall be equal to 105 percent of the mean of the per diem reasonable routine service and capital-related costs of extended care services for skilled nursing facilities in rural areas within the same region, determined without regard to the limitations of subsection (a) and adjusted for different area wage levels.

“(C) The per diem amounts determined under subparagraph (B) shall not exceed the limit on routine service costs determined under subsection (a) with respect to the facility, adjusted to take into account average capital-related costs with respect to the type and location of the facility.

“(3) For purposes of this subsection, urban and rural areas shall be determined in the same manner as for purposes of subsection (a), and the term ‘region’ shall have the same meaning as under section 1886(d)(2)(D).

“(4) The Secretary shall establish the prospective payment amounts for each fiscal year at least 90 days prior to the beginning of such fiscal year, on the basis of the most recent data available for a 12-month period. A skilled nursing facility must notify the Secretary of its intention to be paid pursuant to this subsection for a fiscal year within 60 days after the Secretary establishes the final prospective payment amounts for such fiscal year.

Notice.

“(5) The Secretary shall provide for a simplified cost report to be filed by facilities being paid pursuant to this subsection, which shall require only the cost information necessary for determining prospective payment amounts pursuant to paragraph (2) and reasonable costs of ancillary services.

Report.

“(6) In lieu of payment on a cost basis for ancillary services provided by a facility which is being paid pursuant to this subsection, the Secretary may pay for such ancillary services on a reasonable charge basis if the Secretary determines that such payment basis will provide an equitable level of reimbursement and will ease the reporting burden of the facility.”

42 USC 1395yy. (b) PUBLICATION OF DATA RELATING TO ADJUSTMENTS TO SNF LIMITS.—Section 1888(c) of such Act is amended by adding at the end thereof the following: “The Secretary shall publish the data and criteria to be used for purposes of this subsection on an annual basis.”.

42 USC 1395y
note.

(c) REINSTATEMENT OF WAIVER OF LIABILITY PRESUMPTION.—The Secretary of Health and Human Services shall, for purposes of determining whether payments to a skilled nursing facility should be denied pursuant to section 1862(a)(1)(A) of the Social Security Act, apply the same presumption of compliance (5 percent) as in effect under regulations as of July 1, 1985. Such presumption shall apply for the 30-month period beginning with the first month beginning after the date of the enactment of this Act.

42 USC 1395yy
note.

(d) EFFECTIVE DATES.—(1) The amendment made by subsection (a) shall apply to fiscal years beginning on or after October 1, 1986.

(2) The amendment made by subsection (b) shall become effective on the date of the enactment of this Act.

SEC. 9127. ADDITIONAL MEMBERS OF PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.

(a) EXPANSION OF MEMBERSHIP.—Section 1886(e)(6)(A) of the Social Security Act (42 U.S.C. 1395ww(e)(6)(A)) is amended by striking out “15 individuals” and inserting in lieu thereof “17 individuals”.

42 USC 1395ww
note.

(b) APPOINTMENTS.—The Director of the Congressional Office of Technology Assessment shall appoint the two additional members of the Prospective Payment Assessment Commission, as required by the amendment made by subsection (a), no later than 60 days after the date of the enactment of this Act, for terms of three years.

SEC. 9128. SENSE OF THE SENATE WITH RESPECT TO INPATIENT HOSPITAL DEDUCTIBLE.

In view of the \$92 Medicare hospital deductible increase that went into effect January 1, 1986, it is the sense of the Senate that the Committee on Finance should report legislation which will reform calculation of the annual increase in such deductible so that it is more consistent with annual increases in Medicare payments to hospitals.

SEC. 9129. MEDICARE COVERAGE OF STATE AND LOCAL EMPLOYEES.

For provision providing for medicare coverage of certain State and local employees, see section 13205 of this Act.

PART 2—PROVISIONS RELATING TO PARTS A AND B OF MEDICARE

Subpart A—Payment-Related Provisions

SEC. 9201. EXTENSION OF WORKING AGED PROVISION.

(a) EXTENSION OF SECONDARY PAYOR STATUS BEYOND AGE 69.—Section 1862(b)(3)(A) of the Social Security Act (42 U.S.C. 1395y(b)(3)(A)) is amended—

(1) in clause (i), by striking out “who is under 70 years of age during any part of such month” and “, if the spouse is under 70 years of age during any part of such month”, and

(2) in clause (iii), by striking out “and ending with the month before the month in which such individual attains the age of 70”.

(b) EXTENSION OF AGE DISCRIMINATION PROVISIONS.—

(1) Section 4(g)(1) of the Age Discrimination in Employment Act of 1967 (29 U.S.C. 623(g)(1)) is amended by striking out “through 69” and inserting in lieu thereof “or older” each place it appears.

(2) Section 12(a) of such Act (29 U.S.C. 631(a)) is amended by inserting “(except the provisions of section 4(g))” after “Act”.

(3) Section 4 of such Act (29 U.S.C. 623) is amended by redesignating the second subsection (g), added by section 802 of the Older Americans Act Amendments of 1984, as subsection (h).

98 Stat. 1792.

(c) CONFORMING AMENDMENTS.—

(1) SPECIAL ENROLLMENT PERIOD.—Paragraph (3) of section 1837(i) of the Social Security Act (42 U.S.C. 1395p(i)(3)) is amended to read as follows:

“(3) The special enrollment period referred to in paragraphs (1) and (2) is the period beginning with the first day of the first month in which the individual is no longer enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of current employment and ending seven months later.”.

42 USC 1395y.

(2) EFFECTIVE DATE OF ENROLLMENT.—Subsection (e) of section 1838 of the Social Security Act (42 U.S.C. 1395q) is amended to read as follows:

“(e) Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1837(i)(3)—

42 USC 1395p.

“(1) in the first month of the special enrollment period, the coverage period shall begin on the first day of that month, or

“(2) in a month after the first month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.”

(d) EFFECTIVE DATES.—(1) The amendments made by subsection (a) shall apply with respect to items and services furnished on or after May 1, 1986.

42 USC 1395y
note.

(2) The amendments made by subsections (b) and (c) shall become effective on May 1, 1986.

42 USC 1395p
note.

SEC. 9202. PAYMENTS TO HOSPITALS FOR DIRECT COSTS OF MEDICAL EDUCATION.

(a) MEDICARE PAYMENT METHODOLOGY.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

“(h) PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—

“(1) SUBSTITUTION OF SPECIAL PAYMENT RULES.—Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of hospitals for direct graduate medical education costs, the Secretary shall provide for payments for such costs in accordance with paragraph (3) of this subsection. In providing for such payments, the Secretary shall provide for an allocation of such payments between part A and part B (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of

42 USC 1395x.

hospitals associated with the provision of services under each respective part.

"(2) DETERMINATION OF HOSPITAL-SPECIFIC APPROVED FTE RESIDENT AMOUNTS.—The Secretary shall determine, for each hospital with an approved medical residency training program, an approved FTE resident amount for each cost reporting period beginning on or after July 1, 1985, as follows:

"(A) DETERMINING ALLOWABLE AVERAGE COST PER FTE RESIDENT IN A HOSPITAL'S BASE PERIOD.—The Secretary shall determine, for the hospital's cost reporting period that began during fiscal year 1984, the average amount recognized as reasonable under this title for direct graduate medical education costs of the hospital for each full-time-equivalent resident.

"(B) UPDATING TO THE FIRST COST REPORTING PERIOD.—

"(i) IN GENERAL.—The Secretary shall update each average amount determined under subparagraph (A) by the percentage increase in the consumer price index during the 12-month cost reporting period described in such subparagraph.

"(ii) EXCEPTION.—The Secretary shall not perform an update under clause (i) in the case of a hospital if the hospital's reporting period, described in subparagraph (A), began on or after July 1, 1984, and before October 1, 1984.

"(C) AMOUNT FOR FIRST COST REPORTING PERIOD.—For the first cost reporting period of the hospital beginning on or after July 1, 1985, the approved FTE resident amount for the hospital is equal to the amount determined under paragraph (B) increased by 1 percent.

"(D) AMOUNT FOR SUBSEQUENT COST REPORTING PERIODS.—For each subsequent cost reporting period, the approved FTE resident amount for the hospital is equal to the amount determined under this paragraph for the previous cost reporting period updated, through the midpoint of the period, by projecting the estimated percentage change in the consumer price index during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous under- or over-estimations under this subparagraph in the projected percentage change in the consumer price index.

"(E) TREATMENT OF CERTAIN HOSPITALS.—In the case of a hospital that did not have an approved medical residency training program or was not participating in the program under this title for a cost reporting period beginning during fiscal year 1984, the Secretary shall, for the first such period for which it has such a residency training program and is participating under this title, provide for such approved FTE resident amount as the Secretary determines to be appropriate, based on approved FTE resident amounts for comparable programs.

"(3) HOSPITAL PAYMENT AMOUNT PER RESIDENT.—

"(A) IN GENERAL.—The payment amount, for a hospital cost reporting period beginning on or after July 1, 1985, is equal to the product of—

"(i) the aggregate approved amount (as defined in subparagraph (B)) for that period, and

“(ii) the hospital’s medicare patient load (as defined in subparagraph (C)) for that period.

“(B) AGGREGATE APPROVED AMOUNT.—As used in subparagraph (A), the term ‘aggregate approved amount’ means, for a hospital cost reporting period, the product of—

“(i) the hospital’s approved FTE resident amount (determined under paragraph (2)) for that period, and

“(ii) the weighted average number of full-time-equivalent residents (as determined under paragraph (4)) in the hospital’s approved medical residency training programs in that period.

“(C) MEDICARE PATIENT LOAD.—As used in subparagraph (A), the term ‘medicare patient load’ means, with respect to a hospital’s cost reporting period, the fraction of the total number of inpatient-bed-days (as established by the Secretary) during the period which are attributable to patients with respect to whom payment may be made under part A.

“(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

“(A) RULES.—The Secretary shall establish rules consistent with this paragraph for the computation of the number of full-time-equivalent residents in an approved medical residency training program.

“(B) ADJUSTMENT FOR PART-YEAR OR PART-TIME RESIDENTS.—Such rules shall take into account individuals who serve as residents for only a portion of a period with a hospital or simultaneously with more than one hospital.

“(C) WEIGHTING FACTORS FOR CERTAIN RESIDENTS.—Subject to subparagraph (E), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

“(i) before July 1, 1986, for each resident the weighting factor is 1.00,

“(ii) on or after July 1, 1986, for a resident who is in the resident’s initial residency period (as defined in paragraph (5)(F)), the weighting factor is 1.00,

“(iii) on or after July 1, 1986, and before July 1, 1987, for a resident who is not in the resident’s initial residency period (as defined in paragraph (5)(F)), the weighting factor is .75, and

“(iv) on or after July 1, 1987, for a resident who is not in the resident’s initial residency period (as defined in paragraph (5)(F)), the weighting factor is .50.

“(E) FOREIGN MEDICAL GRADUATES REQUIRED TO PASS FMGEMS EXAMINATION.—

“(i) IN GENERAL.—Except as provided in clause (ii), such rules shall provide that, in the case of an individual who is a foreign medical graduate (as defined in paragraph (5)(D)), the individual shall not be counted as a resident on or after July 1, 1986, unless—

“(I) the individual has passed the FMGEMS examination (as defined in paragraph (5)(E)), or

“(II) the individual has previously received certification from, or has previously passed the examination of, the Educational Commission for Foreign Medical Graduates.

“(ii) **TRANSITION FOR CURRENT FMGS.**—On or after July 1, 1986, in the case of a foreign medical graduate who—

“(I) has served as a resident before July 1, 1986, and is serving as a resident after that date, but

“(II) has not passed the FMGEMS examination or a previous examination of the Educational Commission for Foreign Medical Graduates before July 1, 1986,

the individual shall be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted.

“(5) **DEFINITIONS AND SPECIAL RULES.**—As used in this subsection:

“(A) **APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.**—The term ‘approved medical residency training program’ means a residency or other postgraduate medical training program participation in which may be counted toward certification in a specialty or subspecialty and includes formal postgraduate training programs in geriatric medicine approved by the Secretary.

“(B) **CONSUMER PRICE INDEX.**—As used in this paragraph, the term ‘consumer price index’ refers to the Consumer Price Index for All Urban Consumers (United States city average), as published by the Secretary of Commerce.

“(C) **DIRECT GRADUATE MEDICAL EDUCATION COSTS.**—The term ‘direct graduate medical education costs’ means direct costs of approved educational activities for approved medical residency training programs.

“(D) **FOREIGN MEDICAL GRADUATE.**—The term ‘foreign medical graduate’ means a resident who is not a graduate of—

“(i) a school of medicine accredited by the Liaison Committee on Medical Education of the American Medical Association and the Association of American Medical Colleges (or approved by such Committee as meeting the standards necessary for such accreditation),

“(ii) a school of osteopathy accredited by the American Osteopathic Association, or approved by such Association as meeting the standards necessary for such accreditation, or

“(iii) a school of dentistry or podiatry which is accredited (or meets the standards for accreditation) by an organization recognized by the Secretary for such purpose.

“(E) **FMGEMS EXAMINATION.**—The term ‘FMGEMS examination’ means parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences recognized by the Secretary for this purpose.

“(F) **INITIAL RESIDENCY PERIOD.**—The term ‘initial residency period’ means the period of board eligibility plus one year, except that—

“(i) except as provided in clause (ii), in no case shall the initial period of residency exceed an aggregate period of formal training of more than five years for any individual, and

“(ii) a period, of not more than two years, during which an individual is in a geriatric residency or fellowship program which meets such criteria as the Secretary may establish, shall be treated as part of the initial residency period, but shall not be counted against any limitation on the initial residency period. The initial residency period shall be determined, with respect to a resident, as of the time the resident enters the residency training program.

“(G) PERIOD OF BOARD ELIGIBILITY.—

“(i) GENERAL RULE.—Subject to clauses (ii) and (iii), the term ‘period of board eligibility’ means, for a resident, the minimum number of years of formal training necessary to satisfy the requirements for initial board eligibility in the particular specialty for which the resident is training.

“(ii) APPLICATION OF 1985-1986 DIRECTORY.—Except as provided in clause (iii), the period of board eligibility shall be such period specified in the 1985-1986 Directory of Residency Training Programs published by the Accreditation Council on Graduate Medical Education.

“(iii) CHANGES IN PERIOD OF BOARD ELIGIBILITY.—On or after July 1, 1989, if the Accreditation Council on Graduate Medical Education, in its Directory of Residency Training Programs—

“(I) increases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, above the period specified in its 1985-1986 Directory, the Secretary may increase the period of board eligibility for that specialty, but not to exceed the period of board eligibility specified in that later Directory, or

“(II) decreases the minimum number of years of formal training necessary to satisfy the requirements for a specialty, below the period specified in its 1985-1986 Directory, the Secretary may decrease the period of board eligibility for that specialty, but not below the period of board eligibility specified in that later Directory.

“(H) RESIDENT.—The term ‘resident’ includes an intern or other participant in an approved medical residency training program.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to hospital cost reporting periods beginning on or after July 1, 1985.

(c) STUDIES BY SECRETARY.—(1) The Secretary of Health and Human Services shall conduct a study with respect to approved educational activities relating to nursing and other health professions for which reimbursement is made to hospitals under title XVIII of the Social Security Act. The study shall address—

(A) the types and numbers of such programs, and number of students supported or trained under each program;

(B) the fiscal and administrative relationships between the hospitals involved and the schools with which the programs and students are affiliated; and

(C) the types and amounts of expenses of such programs for which reimbursement is made, and the financial and other

42 USC 1395ww
note.

42 USC 1395ww
note.

42 USC 1395c.

contributions which accrue to the hospital as a consequence of having such programs.

The Secretary shall report the results of such study to the Committee on Finance of the Senate and the Committees on Ways and Means and Energy and Commerce of the House of Representatives prior to December 31, 1987.

(2) The Secretary shall conduct a separate study of the advisability of continuing or terminating the exception under section 1886(h)(5)(F)(ii) of the Social Security Act for geriatric residencies and fellowships, and of expanding such exception to cover other educational activities, particularly those which are necessary to meet the projected health care needs of Medicare beneficiaries. Such study shall also examine the adequacy of the supply of faculty in the field of geriatrics. The Secretary shall report the results of such study to the committees described in paragraph (1) prior to July 1, 1990.

(d) GAO STUDY.—(1) The Comptroller General shall conduct a study of the variation in the amounts of payments made under title XVIII of the Social Security Act with respect to patients in different teaching hospital settings and in the amounts of such payments which are made with respect to patients who are treated in teaching and nonteaching hospital settings. Such study shall identify the components of such payments (including payments with respect to inpatient hospital services, physicians' services, and capital costs, and, in the case of teaching hospital patients, payments with respect to direct and indirect teaching costs) and shall account, to the extent feasible, for any variations in the amounts of the payment components between teaching and nonteaching settings and among different teaching settings.

(2) In carrying out such study, the Comptroller General may utilize a sample of hospital patients and any other data sources which he deems appropriate, and shall, to the extent feasible, control for differences in severity of illness levels, area wage levels, levels of physician reasonable charges for like services and procedures, and for other factors which could affect the comparability of patients and of payments between teaching and nonteaching settings and among teaching settings. The information obtained in the study shall be coordinated with the information obtained in conducting the study of teaching physicians' services under section 2307(c) of the Deficit Reduction Act of 1984.

(3) The Comptroller General shall report the results of the study to the committees described in subsection (c)(1) prior to December 31, 1987.

(e) REPORT ON UNIFORMITY OF APPROVED FTE RESIDENT AMOUNTS.—The Secretary of Health and Human Services shall report to the committees described in subsection (c)(1), not later than December 31, 1987, on whether section 1886(h) of the Social Security Act should be revised to provide for greater uniformity in the approved FTE resident amounts established under paragraph (2) of that section, and, if so, how such revisions should be implemented.

(f) STUDY ON FOREIGN MEDICAL GRADUATES.—The Secretary of Health and Human Services shall study, and report to the committees described in subsection (c)(1), not later than December 31, 1987, respecting the use of physicians who are foreign medical graduates (within the meaning of section 1886(h)(5)(D) of the Social Security Act) in the provision of health care services (particularly inpatient

Ante, p. 171.

42 USC 1395ww
note.
42 USC 1395c.

98 Stat. 1073.

42 USC 1395ww
note.

42 USC 1395ww
note.

and outpatient hospital services) to medicare beneficiaries. Such study shall evaluate—

- (1) the types of services provided;
- (2) the cost of providing such services, relative to the cost of other physicians providing the services or other approaches to providing the services;
- (3) any deficiencies in the quality of the services provided, and methods of assuring the quality of such services; and
- (4) the impact on costs of and access to services if medicare payment for hospitals' costs of graduate medical education of foreign medical graduates were phased out.

(g) **ESTABLISHING PHYSICIAN IDENTIFIER SYSTEM.**—The Secretary of Health and Human Services shall establish a system, for implementation not later than July 1, 1987, which provides for a unique identifier for each physician who furnishes services for which payment may be made under title XVIII of the Social Security Act.

42 USC 1395ww
note.

(h) **PAPERWORK REDUCTION.**—Chapter 35 of title 44, United States Code, shall not apply to information required for purposes of carrying out this section and the amendments made by this section.

42 USC 1395c.
42 USC 1395ww
note.
44 USC 3501 *et seq.*

(i) **PROHIBITING A LIMIT ON INCREASES ON DIRECT MEDICAL EDUCATION COSTS.**—(1) Section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)), as amended by section 9107(b) of this title, is further amended by adding at the end the following new subparagraph:

“(Q) Except as otherwise explicitly authorized, the Secretary is not authorized to limit the rate of increase on allowable costs of approved medical educational activities.”.

(2) The amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after July 1, 1985.

42 USC 1395x
note.

(j) **SPECIAL TREATMENT OF STATES FORMERLY UNDER WAIVER.**—In the case of a hospital in a State that has had a waiver approved under section 1886(c) of the Social Security Act, for cost reporting periods beginning on or after January 1, 1986, if the waiver is terminated—

42 USC 1395ww
note.
Ante, p. 161.

(1) the Secretary of Health and Human Services shall permit the hospital to change the method by which it allocates administrative and general costs to the direct medical education cost centers to the method specified in the medicare cost report;

(2) the Secretary may make appropriate adjustments in the regional adjusted DRG prospective payment rate (for the region in which the State is located), based on the assumption that all teaching hospitals in the State use the medicare cost report; and

(3) the Secretary shall adjust the hospital-specific portion of payment under section 1886(d) of such Act for any such hospital that actually chooses to use the medicare cost report.

The Secretary shall implement this subsection based on the best available data.

SEC. 9204. MORATORIUM ON LABORATORY PAYMENT DEMONSTRATION.

(a) **MORATORIUM.**—Prior to January 1, 1987, the Secretary of Health and Human Services shall not conduct any demonstration projects relating to competitive bidding as a method of purchasing laboratory services under title XVIII of the Social Security Act. The Secretary may contract for the design of, and site selection for, such demonstration projects.

42 USC 1395ww
note.

Contracts.
42 USC 1395c.

(b) **COOPERATION IN STUDY.**—The Secretary of Health and Human Services and the Comptroller General shall assist representatives of clinical laboratories in the industry's conduct of a study to determine whether methods exist which are better than competitive bidding for purposes of utilizing competitive market forces in setting payment levels for laboratory services under title XVIII of the Social Security Act. If such a study is conducted by the clinical laboratory industry, the Secretary and the Comptroller General shall comment on such study and submit such comments and the study to the Senate Committee on Finance and the House Committees on Ways and Means and Energy and Commerce.

42 USC 1395c.

42 USC 1395y
note.**SEC. 9205. HOME HEALTH WAIVER OF LIABILITY.**

The Secretary of Health and Human Services shall, for purposes of determining whether payments to a home health agency should be denied pursuant to section 1862(a)(1)(A) of the Social Security Act, apply a presumption of compliance (2.5 percent) in the same manner as under the regulations in effect as of July 1, 1985. Such presumption shall apply until 12 months after the date on which ten regional intermediaries have commenced operations to service home health agencies, as required under section 1816(e)(4) of the Social Security Act.

42 USC 1395y.

42 USC 1395h.

Subpart B—Other Provisions**SEC. 9211. PROVISIONS RELATING TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.**

(a) **FINANCIAL RESPONSIBILITY FOR PATIENTS HOSPITALIZED ON THE EFFECTIVE DATE OF AN ENROLLMENT OR DISENROLLMENT.**—(1) Subsection (c) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended by adding at the end the following new paragraph:

Contract.

“(7) A risk-sharing contract under this section shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

42 USC 1395ww.

“(A) enrollment with an eligible organization under this section—

“(i) payment for such services until the date of the individual's discharge shall be made under this title as if the individual were not enrolled with the organization,

“(ii) the organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

“(iii) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this section; or

“(B) termination of enrollment with an eligible organization under this section—

“(i) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

“(ii) payment for such services during the stay shall not be made under section 1886(d), and

“(iii) the organization shall not receive any payment with respect to the individual under this section during the period the individual is not enrolled.”

(2) Subsection (a)(3) of such section is amended by striking out "Payments" and inserting in lieu thereof "Subject to subsection (c)(7), payments".

(3) Subsection (a)(6) of such section is amended by striking out "If" and inserting in lieu thereof "Subject to subsection (c)(7), if".

(b) DISENROLLMENTS.—

(1) **EFFECTIVE DATE.**—Subsection (c)(3)(B) of such section is amended by striking out "a full calendar month after" and inserting in lieu thereof "the date on which".

(2) **INFORMATION.**—Such subsection is further amended by adding at the end the following: "In the case of an individual's termination of enrollment, the organization shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization and may not receive benefits under this title other than through the organization.".

(c) **REVIEW OF MARKETING MATERIAL.**—Subsection (c)(3)(C) of such section is amended by adding at the end the following: "No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization under this section unless (i) at least 45 days before its distribution, the organization has submitted the material to the Secretary for review and (ii) the Secretary has not disapproved the distribution of the material. The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.".

Prohibitions.

(d) **PROMPT PUBLICATION OF AAPCC.**—Subsection (a)(1)(A) of such section is amended by inserting after "The Secretary shall annually determine" the following: ", and shall publish not later than September 7 before the calendar year concerned".

(e) EFFECTIVE DATES.—

(1) **FINANCIAL RESPONSIBILITY.**—The amendments made by subsection (a) shall apply to enrollments and disenrollments that become effective on or after the date of the enactment of this Act.

(2) **DISENROLLMENTS.**—The amendments made by subsection (b) shall apply to requests for termination of enrollment submitted on or after May 1, 1986.

(3) **MATERIAL REVIEW.**—(A) The amendment made by subsection (c) shall not apply to material which has been distributed before July 1, 1986.

(B) Such amendment also shall not apply so as to require the submission of material which is distributed before July 1, 1986.

(C) Such amendment shall also not apply to material which the Secretary determines has been prepared before the date of the enactment of this Act and for which a commitment for distribution has been made, if the application of such amendment would constitute a hardship for the organization involved.

(4) **PUBLICATION.**—The amendment made by subsection (d) shall apply to determinations of per capita rates of payment for 1987 and subsequent years.

(5) **NECESSARY MODIFICATION OF CONTRACTS.**—The Secretary of Health and Human Services shall provide for such changes in

42 USC 1395mm
note.

42 USC 1395
mm.

the risk-sharing contracts which have been entered into under section 1876 of the Social Security Act as may be necessary to conform to the requirements imposed by the amendments made by this section on a timely basis.

SEC. 9213. REMOVAL OF PROHIBITION ON COMMENTS BY MEDICARE AND SOCIAL SECURITY ACTUARIES RELATING TO ECONOMIC ASSUMPTIONS.

(a) **FEDERAL OLD-AGE AND DISABILITY INSURANCE TRUST FUND.**—Section 201(c) of the Social Security Act (42 U.S.C. 401(c)) is amended by striking out “: *Provided*, That the certification shall not refer to economic assumptions underlying the Trustee’s report, and shall” and inserting in lieu thereof “. Such report shall”.

(b) **MEDICARE TRUST FUNDS.**—Sections 1817(b) and 1841(b) of such Act (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking out “: *Provided*, That the certification shall not refer to economic assumptions underlying the Trustee’s report”.

42 USC 401 note.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall become effective on the date of the enactment of this Act.

SEC. 9214. LIMITATION ON MERGER OF END STAGE RENAL DISEASE NETWORKS.

42 USC 1395rr
note.

42 USC 1395rr.

The Secretary of Health and Human Services shall maintain renal disease network organizations as authorized under section 1881(c) of the Social Security Act, and may not merge the network organizations into other organizations or entities. The Secretary may consolidate such network organizations, but only if such consolidation does not result in fewer than 14 such organizations being permitted to exist.

SEC. 9215. EXTENSION OF CERTAIN MEDICARE MUNICIPAL HEALTH SERVICES DEMONSTRATION PROJECTS.

Maryland.
Ohio.
Wisconsin.
California.
42 USC 1395b-1
note.
42 USC 1395b-1.

The Secretary of Health and Human Services shall extend, for a period of three additional years, approval of four municipal health services demonstration projects (located in Baltimore, Cincinnati, Milwaukee, and San Jose) authorized under section 402(a) of the Social Security Amendments of 1967.

SEC. 9216. AUDIT AND MEDICAL CLAIMS REVIEW.

42 USC 1395h
note.

(a) **INCREASE IN ACTIVITIES FOR FISCAL YEARS 1986, 1987, AND 1988.**—Section 118 of the Tax Equity and Fiscal Responsibility Act of 1982 (96 Stat. 355) is amended—

(1) by striking out “for fiscal years 1983, 1984, and 1985”,

(2) by striking out “such fiscal years” and inserting in lieu thereof “fiscal years 1983, 1984, and 1985, and \$105,000,000 for each of fiscal years 1986, 1987, and 1988”, and

(3) by striking out “the purpose of carrying out provider cost audits and reviews of medical necessity” and inserting in lieu thereof “purposes of carrying out provider cost audits, of reviewing medical necessity, and of recovering third-party liability payments”.

42 USC 1395h
note.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to fiscal years beginning with fiscal year 1986.

SEC. 9217. LIVER TRANSPLANTS.

(a) The Senate finds that:

(1) There have been more than 600 liver transplants since 1963 and the one year survival rate at qualified institutions is now greater than 70 percent.

(2) There are 4,000 to 4,700 potential candidates in the United States each year who require a liver transplant, but only a small percentage would be eligible for Medicare coverage.

(3) There are currently individuals on waiting lists for liver transplants who will die without Medicare coverage.

(4) After extensive review and consideration of all the available data, an National Institutes of Health expert panel concluded liver transplantation is "a therapeutic modality for end-stage liver disease that deserves broader application" in a limited number of centers where they can be carried out under optimal conditions.

(5) National Institutes of Health further recommended that liver transplants be done in individuals under 18 years of age.

(6) The CHAMPUS program, after considering all relevant data, determined that there was no scientific basis for limiting liver transplants to children under 18 years of age.

(7) The Department of Health and Human Services has determined that liver transplantation is no longer an experimental procedure only for children under 18.

(b) Based upon the above findings, it is the sense of the Senate that:

(1) For the purposes of title XVIII of the Social Security Act, the Secretary immediately reconsider the Medicare liver transplant coverage decision and implement a policy under which a liver transplant shall not be considered to be an experimental procedure for Medicare beneficiaries solely because an individual is over 18 years of age. 42 USC 1395c.

(2) A liver transplant shall be covered under such title when reasonable and medically necessary.

(3) The Secretary shall place appropriate limiting criteria on coverage, including those relating to the patient's condition, the disease state, and the institution providing the care, so as to ensure the highest quality of medical care demonstrated to be consistent with successful outcomes.

SEC. 9218. STUDIES RELATING TO PHYSICAL THERAPISTS AND OTHER PROFESSIONALS.

(a) **SUPERVISION OF HOME HEALTH SERVICES.**—The Secretary of Health and Human Services shall conduct a study of the advisability of changing the requirements of title XVIII of the Social Security Act to allow home health services to be provided under the supervision of a physical therapist or other health care professional, rather than requiring the supervision of a physician or registered nurse.

(b) **OFFICE REQUIREMENT.**—The Secretary of Health and Human Services shall conduct a study on the advisability of deleting the requirement under such title that a physical therapist must have an office equipped with specified equipment, even if such therapist provides all such services in patients' homes.

(c) **REPORTS.**—The Secretary shall report the results of the studies to the Congress prior to October 1, 1986.

SEC. 9219. TECHNICAL CORRECTIONS.

(a) **WORKING AGED TECHNICAL CORRECTIONS.**—

(1) **PREMIUM PENALTY.**—The second sentence of section 1839(b) of the Social Security Act (42 U.S.C. 1395r(b)), as amended by section 2338(a) of the Deficit Reduction Act of 1984, is amended by striking out “months in which” and all that follows through “clause (iv) of such section” and inserting in lieu thereof “months during which the individual has attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(3)(A)(iv)”.

42 USC 1395y.

(2) **SPECIAL ENROLLMENT PERIODS.**—Section 1837(i) of the Social Security Act (42 U.S.C. 1395p), as added by section 2338(b) of the Deficit Reduction Act of 1984, is amended—

(A) in paragraph (1), by amending subparagraph (A) to read as follows:

“(A) has attained the age of 65;” and

(B) in paragraph (2), by redesignating subparagraph (C) as subparagraph (D) and by amending subparagraphs (A) and (B) to read as follows:

“(A) has attained the age of 65;

“(B)(i) has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual’s initial enrollment period, or (ii) is an individual described in paragraph (1)(B);

“(C) has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of the individual’s (or individual’s spouse’s) current employment; and”.

(3) **EFFECTIVE DATES.**—

(A) The amendment made by paragraph (1) shall apply to months beginning with January 1983 for premiums for months beginning with the first month that begins more than 30 days after the date of the enactment of this Act.

(B)(i) The amendments made by paragraph (2) shall apply to enrollments in months beginning with the first effective month (as defined in clause (ii)), except that in the case of any individual who would have a special enrollment period under section 1837(i) of the Social Security Act that would have begun after November 1984 and before the first effective month, the period shall be deemed to begin with the first day of the first effective month.

(ii) For purposes of clause (i), the term “first effective month” means the first month that begins more than 90 days after the date of the enactment of this Act.

(b) **MISCELLANEOUS TECHNICAL CORRECTIONS.**—

(1)(A) Subclause (III) of section 1842(b)(7)(B)(ii) of the Social Security Act (42 U.S.C. 1395u(b)(7)(B)(ii)), as added by section 2307(a)(2)(G) of the Deficit Reduction Act of 1984, is amended by indenting it two additional ems to the right so as to align its left margin with the left margins of subclauses (I) and (II) of that section.

(B) Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)), as inserted by section 2321(e)(3) of the Deficit Reduction Act of 1984, is amended by striking out “at his home” and inserting in lieu thereof “as his home”.

(C) Section 1888(b) of the Social Security Act (42 U.S.C. 1395yy(b)), as added by section 2319(b) of the Deficit Reduction

42 USC 1395r
note.

42 USC 1395p
note.

Act of 1984, is amended by striking out “notwithstanding” and inserting in lieu thereof “notwithstanding”.

(D) The amendments made by this paragraph shall be effective as if they had been originally included in the Deficit Reduction Act of 1984.

42 USC 1395u
note.

(2)(A) Clause (iii) of section 1842(b)(7)(B) of the Social Security Act (42 U.S.C. 1395u(b)(7)(B)), as added by section 3(b)(6) of Public Law 98-617, is amended by moving its alignment two additional ems to the left so as to align its left margin with the left margins of clauses (i) and (ii) of that section.

(B) The amendment made by subparagraph (A) shall be effective as if it had been originally included in Public Law 98-617.

42 USC 1395u
note.

(3)(A) Section 1861(v)(1)(G)(i) of the Social Security Act (42 U.S.C. 1395x(b)(1)(G)(i)), as amended by section 602(d)(1) of the Social Security Amendments of 1983, is amended by inserting, in the matter after subclause (III), “on the basis of” after “(during such period)”.

(B) The amendment made by subparagraph (A) shall be effective as if it had been originally included in the Social Security Amendments of 1983.

42 USC 1395x
note.

SEC. 9220. EXTENSION OF ON LOK WAIVER.

(a) CONTINUED APPROVAL.—

(1) **MEDICARE WAIVERS.**—Notwithstanding any limitations contained in section 222 of the Social Security Amendments of 1972 and section 402(a) of the Social Security Amendments of 1967, the Secretary of Health and Human Services shall continue approval of the risk-sharing application (described in section 603(c)(1) of Public Law 98-21) for waivers of certain requirements of title XVIII of the Social Security Act after the end of the period described in that section.

42 USC 1395b-1
and note, 1395ll.
42 USC 1395b-1.
42 USC 1395b-1
note.
42 USC 1395c.
42 USC 1315.

(2) **MEDICAID WAIVERS.**—Notwithstanding any limitations contained in section 1115 of the Social Security Act, the Secretary shall approve any application of the Department of Health Services, State of California, for a waiver of requirements of title XIX of such Act in order to continue carrying out the demonstration project referred to in section 603(c)(2) of Public Law 98-21 after the end of the period described in that section.

42 USC 1396.

(b) **TERMS, CONDITIONS, AND PERIOD OF APPROVAL.**—The Secretary's approval of an application (or renewal of an application) under this section—

(1) shall be on the same terms and conditions as applied with respect to the corresponding application under section 603(c) of Public Law 98-21 as of July 1, 1985, except that requirements relating to collection and evaluation of information for demonstration purposes (and not for operational purposes) shall not apply; and

(2) shall remain in effect until such time as the Secretary finds that the applicant no longer complies with the terms and conditions described in paragraph (1).

SEC. 9221. CONTINUATION OF “ACCESS: MEDICARE” DEMONSTRATION PROJECT.

(a) **APPROVAL OF APPLICATION.**—The Secretary of Health and Human Services shall approve any application for a waiver of any requirement of titles XVIII and XIX of the Social Security Act necessary to provide for the continuation, through September 30,

42 USC 1395c,
1396.

42 USC 1395b-1
and note, 1395ll.
42 USC 1395b-1.

1986, of the "Access: Medicare" demonstration project carried out pursuant to section 222 of the Social Security Amendments of 1972 and section 402(a) of the Social Security Amendments of 1967 by Monroe County Long Term Care Program, Inc.

(b) **TERMS AND CONDITIONS.**—The Secretary's approval of an application (or renewal of an application) under subsection (a) shall be on the same terms and conditions as applied to the demonstration project as in effect on August 31, 1985.

PART 3—PROVISIONS RELATING TO PART B OF MEDICARE

Subpart A—Payment-Related Provisions

SEC. 9301. MEDICARE PHYSICIAN PAYMENT PROVISIONS.

(a) **EXTENSION OF CURRENT FREEZE ON PAYMENT RATES THROUGH APRIL 30, 1986.**—Section 5(c) of the Emergency Extension Act of 1985 (Public Law 99-107), as amended by section 9101(a) of this title, is further amended by adding at the end the following new paragraph:

"(2) **PHYSICIAN PAYMENTS.**—For purposes of subsection (b), the term 'extension period' means the period beginning on October 1, 1985, and ending on April 30, 1986."

(b) **EXTENSION OF CERTAIN PROVISIONS THROUGH DECEMBER 31, 1986.**—

(1) **EXTENSION.**—Section 1842(b)(4) of the Social Security Act (42 U.S.C. 1395u(b)(4)) is amended—

(A) in subparagraph (A)—

(i) by inserting "(i)" after "(4)(A)", and

(ii) by adding at the end the following new clauses:

"(ii)(I) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

"(II) In determining the prevailing charge levels under the fourth sentence of paragraph (3) for physicians' services furnished during the 8-month period beginning May 1, 1986, by a physician who is a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall permit an additional one percentage point increase in the increase otherwise permitted under that sentence.

"(iii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during a 12-month period beginning on or after January 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for services furnished during the previous calendar year (without regard to clause (ii)(II)) for physicians who were participating physicians during that year."

(B) in subparagraph (B)—

(i) by inserting "(i)" after "(B)", and

(ii) by adding at the end the following new clause:

42 USC 1395ww
note.

“(ii) In determining the reasonable charge under paragraph (3) for physicians’ services furnished during the 8-month period beginning May 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services—

“(I) if the physician was not a participating physician at any time during the 12-month period beginning on October 1, 1984, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983, and

“(II) if the physician was a participating physician at any time during the 12-month period beginning on October 1, 1984, the physician’s customary charges shall be determined based upon the physician’s actual charges billed during the 12-month period ending on March 31, 1985.”;

(C) in subparagraph (C)—

(i) by inserting “(i)” after “(C)”,

(ii) by striking out “(A)” and inserting in lieu thereof “(A)(i)” each place it appears, and

(iii) by adding at the end the following new clause:

“(ii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians’ services furnished during the periods beginning after December 31, 1986, by a physician who was not a participating physician on that date, the Secretary shall treat the level as set under subparagraph (A)(ii) as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)(ii).”;

(D) in subparagraph (D)—

(i) by striking out “In determining” and all that follows through “subsection (h)(1))” and insert in lieu thereof “(i) In determining the customary charges for physicians’ services furnished during the 8-month period beginning May 1, 1986, or the 12-month period beginning January 1, 1987, by a physician who was not a participating physician (as defined in subsection (h)(1)) on September 30, 1985”, and

(ii) by adding at the end the following new clauses:

“(ii) In determining the customary charges for physicians’ services furnished during the 12-month period beginning January 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1)) on April 30, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 7-month period beginning on October 1, 1985, above the level of the physician’s actual charges billed during the 3-month period ending on June 30, 1984.

“(iii) In determining the customary charges for physicians’ services furnished during the 12-month period beginning January 1, 1987, or January 1, 1988, by a physician who is not a participating physician (as defined in subsection (h)(1)) on December 31, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 8-month period beginning on May 1, 1986, above the level of the physician’s actual charges billed during the 3-month period ending on June 30, 1984.”.

(2) CONTINUED ENFORCEMENT.—The first sentence of section 1842(j)(1) of such Act (42 U.S.C. 1395u(j)(1)) is amended to read as follows: “In the case of a physician who is not a participating physician for items and services furnished during a portion of the 30-month period beginning July 1, 1984, the Secretary shall

monitor the physician's actual charges to individuals enrolled under this part for physicians' services during that portion of that period."

42 USC 1395u
note.

42 USC 1395u.

(3) **PERIOD FOR ENTERING PARTICIPATION AGREEMENTS.**—The Secretary of Health and Human Services shall provide, during the month of April 1986, that physicians and suppliers may enter into an agreement under section 1842(h)(1) of the Social Security Act for the 8-month period beginning May 1, 1986, or terminate such an agreement previously entered into for fiscal year 1986. In the case of a physician or supplier who entered into such an agreement for fiscal year 1986, the physician or supplier shall be deemed to have entered into such agreement for such 8-month period and for each succeeding year unless the physician or supplier terminates such agreement before the beginning of the respective period. At the beginning of such 8-month period, the Secretary shall publish a new directory (described in section 1842(h)(4) of that Act, as redesignated by subsection (c)(3)(D) of this section) of participating physicians and suppliers.

42 USC 1395u
note.

(4) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply to services furnished on or after May 1, 1986.
(c) **INCENTIVES FOR PARTICIPATING PHYSICIAN PROGRAM.**—

42 USC 1395u.

(1) **15-MONTH EXTENSION OF TRANSFER OF FUNDS FOR CARRIERS.**—Section 2306(e) of the Deficit Reduction Act of 1984 (Public Law 98-369; 98 Stat. 1073) is amended—

(A) by striking out "and 1985" and inserting in lieu thereof "1985, and 1986",

(B) by striking out "the amendments made by this section" and inserting in lieu thereof "subsections (b)(4), (h), and (j) of section 1842 of the Social Security Act",

(C) by striking out "and" before "not less",

(D) by inserting before the period at the end the following: "and not less than \$18,000,000 for fiscal year 1986", and

(E) by adding at the end the following new sentences: "A significant proportion of such funds shall be used for the expansion of the participating physician and supplier program and for the development of professional relations staffs dedicated to addressing the billing and other problems of physicians and suppliers participating in that program. Such funds for fiscal year 1986 are available for obligation until December 31, 1986."

(2) **IMPROVEMENT OF PARTICIPATING PHYSICIAN DIRECTORIES.**—Section 1842(i) of the Social Security Act (42 U.S.C. 1395u(i)) is amended—

(A) in the first sentence of paragraph (2)—

(i) by striking out "a directory" and inserting in lieu thereof "directories (for appropriate local geographic areas)", and

(ii) by inserting "for that area" before "for that fiscal year";

(B) in the second sentence of paragraph (2), by striking out "The directory" and inserting in lieu thereof "Each directory";

(C) in paragraph (3)—

(i) by striking out "directory" the first place it appears and inserting in lieu thereof "the directories", and

(ii) by striking out "directory" the second place it appears and inserting in lieu thereof "the appropriate area directory or directories"; and

(D) in paragraph (4)—

(i) by striking out "directory" and inserting in lieu thereof "the directories", and

(ii) by adding at the end the following: "The Secretary shall provide that each appropriate area directory is sent to each participating physician located in that area."

(3) **ELIMINATION OF PHYSICIAN ASSIGNMENT RATE LIST.**—Section 1842(i) of such Act is further amended—

42 USC 1395u.

(A) by striking out "(i)(1)" and all that follows through the end of paragraph (1),

(B) by striking out "subsection (h)(1)" in paragraph (2) and inserting in lieu thereof "paragraph (1)",

(C) by striking out "list and" each place it appears in paragraphs (3) and (4), and

(D) by redesignating paragraphs (2) through (4) as paragraphs (4) through (6) of subsection (h), respectively.

(4) **INFORMATION ON THE PARTICIPATING PHYSICIAN AND SUPPLIER PROGRAM IN EXPLANATIONS OF MEDICARE BENEFITS FOR UNASSIGNED CLAIMS.**—Section 1842(h) of such Act, as previously amended by this subsection, is further amended by adding at the end the following new paragraphs:

"(7) The Secretary shall provide that each explanation of benefits provided under this part for services furnished in the United States, in conjunction with the payment of claims under section 1833(a)(1) (made other than on an assignment-related basis, described in paragraph (8)), shall include—

42 USC 1395l.

"(A) a reminder of the participating physician and supplier program established under this subsection (including the limitation on charges that may be imposed by such physicians and suppliers), and

"(B) the toll-free telephone number or numbers, maintained under paragraph (2), at which an individual enrolled under this part may obtain information on participating physicians and suppliers.

"(8) For purposes of this title, a claim is considered to be paid on an 'assignment-related basis' if the claim is paid on the basis of an assignment described in subsection (b)(3)(B)(ii), in accordance with subsection (b)(6)(B), or under the procedure described in section 1870(f)(1)."

42 USC 1395gg.

(5) **EFFECTIVE DATE.**—Section 1842(b)(7) of the Social Security Act, as added by paragraph (4) of this subsection, shall apply to explanations of benefits provided on or after such date (not later than October 1, 1986) as the Secretary of Health and Human Services shall specify.

42 USC 1395u note.

(d) **CHANGING CUSTOMARY AND PREVAILING CHARGE UPDATES FOR PHYSICIAN SERVICES AND OTHER PART B SERVICES FROM OCTOBER TO JANUARY.**—

(1) **PAYMENT UPDATES.**—Section 1842(b)(3) of the Social Security Act (42 U.S.C. 1395u(b)(3)) is amended—

(A) in subparagraph (F), by striking out “(ending on September 30)”;

(B) in the third sentence, by striking out “March 31” and all that follows through “of each year” and inserting in lieu thereof “June 30 last preceding the start of the calendar year”; and

(C) in the eighth sentence, by striking out “the twelve-month period beginning on October 1 in”.

(2) PARTICIPATION AGREEMENTS.—Section 1842(h)(1) of such Act is amended—

(A) in the second sentence—

(i) by striking out “before October 1” and inserting in lieu thereof “before the beginning”,

(ii) by striking out “on the basis of an assignment” and all that follows through “1870(f)(1)” and inserting in lieu thereof “on an assignment-related basis”, and

(iii) by striking out “the 12-month period beginning on October 1 of”; and

(B) in the third sentence—

(i) by striking out “after October 1” and inserting in lieu thereof “after the beginning”, and

(ii) by striking out “12-month period beginning on such October 1” and inserting in lieu thereof “year”.

(3) DIRECTORIES.—The first sentence of section 1842(i)(2) of such Act (which is redesignated as section 1842(h)(4) by subsection (c)(3)(D)), is further amended by striking out “fiscal” each place it appears.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished on or after October 1, 1986.

(5) TRANSITION.—Notwithstanding any other provision of law, for purposes of making payment under part B of title XVIII of the Social Security Act, customary and prevailing charges (and the lowest charges determined under the sixth sentence of section 1842(b)(3) of such Act) for items and services furnished during the period beginning on October 1, 1986, and ending on December 31, 1986, shall be determined on the same basis as for items and services furnished on September 30, 1986.

SEC. 9303. PAYMENT FOR CLINICAL LABORATORY SERVICES.

(a) CHANGING MONTH OF ANNUAL UPDATE FROM JULY TO JANUARY.—

(1) IN GENERAL.—Section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) is amended—

(A) by striking out “June 30, 1987” and “July 1, 1987” and inserting in lieu thereof “December 31, 1987” and “January 1, 1988”, respectively, each place either appears, and

(B) in paragraph (2), by inserting “(to become effective on January 1 of each year)” after “adjusted annually”.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to clinical laboratory diagnostic tests performed on or after July 1, 1986.

(3) TRANSITION.—The Secretary of Health and Human Services shall provide that the annual adjustment under section 1833(h) of the Social Security Act for 1986—

(A) shall take effect on January 1, 1987,

42 USC 1395u.

42 USC 1395u
note.

42 USC 1395u
note.

42 USC 1395j.

42 USC 1395l.

42 USC 1395l
note.

42 USC 1395l
note.

(B) shall apply for the 12-month period beginning on that date, and

(C) shall take into account the percentage increase or decrease in the Consumer Price Index for all urban consumers (United States city average) occurring over an 18-month period, rather than over a 12-month period.

(b) PROVIDING CEILING ON RATES.—

(1) CEILING ON PAYMENTS.—Paragraphs (1)(D)(i) and (2)(D)(i) of section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) are each amended by inserting after “lesser of the amount determined under such fee schedule” the following: “, the limitation amount for that test determined under subsection (h)(4)(B),”.

(2) ESTABLISHMENT OF LIMITATION AMOUNT.—Section 1833(h)(4) of such Act is amended by inserting “(A)” after “(4)” and by adding at the end the following new subparagraph:

“(B) For purposes of subsections (a)(1)(D)(i) and (a)(2)(D)(i), the limitation amount for a clinical diagnostic laboratory test performed—

“(i) on or after July 1, 1986, and before January 1, 1988, is equal to 115 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1), or

“(ii) after December 31, 1987, and so long as a fee schedule for the test has not been established on a nationwide basis, is equal to 110 percent of the median of all the fee schedules established for that test for that laboratory setting under paragraph (1).”.

(3) METHOD OF PAYMENT FOR NON-INDEPENDENT LABORATORIES.—Section 1833(h)(5)(C) of such Act is amended by striking out “which is independent of a physician’s office or” and inserting in lieu thereof “other than”.

(4) EXTENDING MEDICARE PROFICIENCY EXAMINATION AUTHORITY.—Section 1123(a) of such Act (42 U.S.C. 1320a-2(a)) is amended by striking out “September 30, 1983” and inserting in lieu thereof “September 30, 1987”.

(5) EFFECTIVE DATES.—(A) The amendments made by paragraphs (1) and (2) shall apply to clinical diagnostic laboratory tests performed on or after July 1, 1986.

42 USC 1395l
note.

(B) The amendment made by paragraph (3) shall apply to clinical diagnostic laboratory tests performed on or after January 1, 1987.

42 USC 1395l
note.

(C) The amendment made by paragraph (4) shall take effect on the date of the enactment of this Act.

42 USC 1320a-2
note.

(c) REPORT ON MINIMUM STANDARDS FOR CLINICAL LABORATORIES THAT ARE PART OF, OR ASSOCIATED WITH, PHYSICIANS’ OFFICES.—The Secretary of Health and Human Services shall report to Congress, not later than 12 months after the date of the enactment of this Act, on the standards that might be established under the medicare program for clinical laboratories which are part of or associated with a physician’s office to assure the health and safety of individuals with respect to whom the laboratories perform clinical diagnostic laboratory tests for which payment may be made under the program. In recommending standards, the Secretary shall consider the differences in the scope, type, and complexity of tests performed by such laboratories and such other factors as may indicate a need for different standards for laboratories with different characteristics.

SEC. 9304. DETERMINATIONS OF INHERENT REASONABLENESS OF CHARGES AND CUSTOMARY CHARGES FOR CERTAIN FORMER HOSPITAL-COMPENSATED PHYSICIANS.

(a) **REGULATIONS RELATING TO INHERENT REASONABLENESS OF CHARGES.**—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

“(8) The Secretary by regulation shall—

“(A) describe the factors to be used in determining the cases (of particular items or services) in which the application of this subsection results in the determination of a reasonable charge that, by reason of its grossly excessive or grossly deficient amount, is not inherently reasonable, and

“(B) provide in those cases for the factors that will be considered in establishing a reasonable charge that is realistic and equitable.”.

42 USC 1395u
note.

(b) **COMPUTATION OF CUSTOMARY CHARGES FOR CERTAIN FORMER HOSPITAL-COMPENSATED PHYSICIANS.**—(1) In applying section 1842(b) of the Social Security Act to payment for physicians' services performed during the 8-month period beginning May 1, 1986, in the case of a physician who at anytime during the period beginning on October 31, 1982, and ending on January 31, 1985, was a hospital-compensated physician (as defined in paragraph (3)) but who, as of February 1, 1985, was no longer a hospital-compensated physician, the physician's customary charges shall—

(A) be based upon the physician's actual charges billed during the 12-month period ending on March 31, 1985, and

(B) in the case of a physician who was not a participating physician (as defined in section 1842(h)(1) of the Social Security Act) on September 30, 1985, and who is not such a physician on May 1, 1986, be deflated (to take into account the legislative freeze on actual charges for nonparticipating physicians' services) by multiplying the physician's customary charges by .85.

(2) In applying section 1842(b) of the Social Security Act to payment for physicians' services performed during the 8-month period beginning May 1, 1986, in the case of a physician who during the period beginning on February 1, 1985, and ending on December 31, 1986, changes from being a hospital-compensated physician to not being a hospital-compensated physician, the physician's customary charges shall be determined in the same manner as if the physician were considered to be a new physician.

(3) In this subsection, the term “hospital-compensated physician” means, with respect to services furnished to patients of a hospital, a physician who is compensated by the hospital for the furnishing of physicians' services for which payment may be made under this part.

SEC. 9305. PHYSICIAN PAYMENT REVIEW COMMISSION AND DEVELOPMENT OF RELATIVE VALUE SCALE.

(a) **ESTABLISHMENT OF COMMISSION.**—Part B of title XVIII of the Social Security Act is amended by adding at the end the following new section:

“PHYSICIAN PAYMENT REVIEW COMMISSION

42 USC 1395w-1.

“SEC. 1845. (a)(1) The Director of the Congressional Office of Technology Assessment (hereinafter in this section referred to as

the 'Director' and the 'Office', respectively) shall provide for the appointment of a Physician Payment Review Commission (hereinafter in this section referred to as the 'Commission'), to be composed of individuals with expertise in the provision and financing of physicians' services appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service).

"(2) The Commission shall consist of 11 individuals. Members of the Commission shall first be appointed no later than May 1, 1986, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than four members expire in any one year.

"(3) The membership of the Commission shall include physicians, other health professionals, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and representatives of consumers and the elderly. The Director shall seek nominations from a wide range of groups, including—

"(A) national organizations representing physicians, including medical specialty organizations,

"(B) organizations representing the elderly and consumers,

"(C) national organizations representing medical schools,

"(D) national organizations representing hospitals, including teaching hospitals, and

"(E) national organizations representing health benefits programs.

"(b)(1) The Commission shall make recommendations to the Congress, not later than March 1 of each year (beginning with 1987), regarding adjustments to the reasonable charge levels for physicians' services recognized under section 1842(b) and changes in the methodology for determining the rates of payment, and for making payment, for physicians' services under this title and other items and services under this part.

"(2) In making its recommendations, the Commission shall—

"(A) consider, and make recommendations on the feasibility and desirability of reducing, the differences in payment amounts for physicians' services under this part which are based on differences in geographic location or specialty;

"(B) review the input costs (including time, professional skills, and risks) associated with the provision of different physicians' services;

"(C) identify those charges recognized as reasonable under section 1842(b) which are significantly out-of-line, based on the considerations of subparagraphs (A) and (B);

42 USC 1395u.

"(D) assess the likely impact of different adjustments in payment rates, particularly their impact on physician participation in the participation program established under section 1842(h) and on beneficiary access to necessary physicians' services;

"(E) make recommendations on ways to increase physician participation in that participation program and the acceptance of payment under this part on an assignment-related basis;

"(F) make recommendations respecting the advisability and feasibility of making changes in the payment system for physicians' services under this part based on (i) the Secretary's study under section 603(b)(2) of the Social Security Amendments of 1983 (relating to payments for physicians' services furnished to

42 USC 1395b-1 note.

hospital inpatients on the basis of diagnosis-related groups) and (ii) the Office's report under section 2309 of the Deficit Reduction Act of 1984 (relating to physician reimbursement under this part);

"(G) identify those procedures, involving the use of assistants at surgery, for which payment for those assistants should not be made under this title without prior approval; and

"(H) identify those procedures for which an opinion of a second physician should be required before payment is made under this title.

"(3) The Commission also shall advise and make recommendations to the Secretary respecting the development of the relative value scale under subsection (e).

42 USC 1395ww.

"(c)(1) The following provisions of section 1886(e)(6) shall apply to the Commission in the same manner as they apply to the Prospective Payment Assessment Commission:

"(A) Subparagraph (C) (relating to staffing and administration generally).

"(B) Subparagraph (D) (relating to compensation of members).

"(C) Subparagraph (F) (relating to access to information).

"(D) Subparagraph (G) (relating to reports and use of funds).

"(E) Subparagraph (H) (relating to periodic GAO audits).

"(F) Subparagraph (J) (relating to requests for appropriations).

"(2) In order to carry out its functions, the Commission shall collect and assess information on medical and surgical procedures and services, including information on regional variations of medical practice. In collecting and assessing information, the Commission shall—

"(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

"(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate for the development of useful and valid guidelines by the Commission, and

"(C) adopt procedures allowing any interested party to submit information with respect to physicians' services (including new practices, such as the use of new technologies and treatment modalities), which information the Commission shall consider in making reports and recommendations to the Secretary and Congress.

"(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Supplementary Medical Insurance Trust Fund."

(b) DEVELOPMENT OF RELATIVE VALUE SCALE FOR PHYSICIANS' SERVICES.—Section 1845 of the Social Security Act, as added by subsection (a), is further amended by adding at the end the following new subsection:

"(e)(1) The Secretary shall develop a relative value scale that establishes a numerical relationship among the various physicians' services for which payment may be made under this part or under State plans approved under title XIX.

42 USC 1396.

"(2) In developing the scale, the Secretary shall consider among other items—

“(A) the report of the Office of Technology Assessment under section 2309 of the Deficit Reduction Act of 1984,

42 USC 1395l
note.

“(B) the recommendations of the Physician Payment Review Commission under subsection (b)(3), and

“(C) factors with respect to the input costs for furnishing particular physicians’ services, such as—

“(i) the differences in costs of furnishing services in different settings,

“(ii) the differences in skill levels and training required to perform the services, and

“(iii) the time required, and risk involved, in furnishing different services.

“(3) The Secretary shall complete the development of the relative value scale under this section, and report to Congress on the development, not later than July 1, 1987. The report shall include recommendations for the application of the scale to payment for physicians’ services furnished under this part on or after January 1, 1988.”

Report.

SEC. 9306. LIMITATION ON MEDICARE PAYMENT FOR POST-CATARACT SURGERY PATIENTS.

(a) DETERMINATION OF SEPARATE PAYMENT AMOUNTS FOR PROSTHETIC LENSES AND PROFESSIONAL SERVICES.—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended by adding after paragraph (8), added by section 9304(a) of this title, the following new paragraph:

“(9) In providing payment for cataract eyeglasses and cataract contact lenses, and professional services relating to them, under this part, each carrier shall—

“(A) provide for separate determinations of the payment amount for the eyeglasses and lenses and of the payment amount for the professional services of a physician (as defined in section 1861(r)), and

42 USC 1395x.

“(B) not recognize as reasonable for such eyeglasses and lenses more than such amount as the Secretary establishes in guidelines relating to the inherent reasonableness of charges for such eyeglasses and lenses.”

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after April 1, 1986.

42 USC 1395u
note.

SEC. 9307. PAYMENT FOR ASSISTANTS AT SURGERY FOR CERTAIN CATARACT OPERATIONS AND OTHER OPERATIONS.

(a) LIMITATION ON PAYMENT.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(1) by striking out “or” at the end of paragraph (13),

(2) by striking out the period at the end of paragraph (14) and inserting in lieu thereof “; or”, and

(3) by adding at the end the following new paragraph:

“(15) which are for services of an assistant at surgery in a cataract operation unless, before the surgery is performed, the appropriate utilization and quality control peer review organization (under part B of title XI) or a carrier under section 1842 has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition.”

42 USC 1320c.
42 USC 1395u.

(b) ADDITIONAL PRO FUNCTIONS.—Section 1154(a)(8) of such Act (42 U.S.C. 1320c-3(a)(8)) is amended by inserting before the period at

Ante, p. 193.

the end the following: "or as may be required to carry out section 1862(a)(15)".

(c) **PROHIBITION FOR SUBMITTING BILL FOR WHICH PAYMENT MAY NOT BE MADE.**—Section 1842 of such Act (42 U.S.C. 1395u) is amended—

(1) in subsection (j)(2), by inserting "or subsection (k)" after "paragraph (1)", and

(2) by adding at the end the following new subsection:

"(k)(1) If a physician knowingly and willfully bills an individual enrolled under this part for charges for services as an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

"(2) If a physician knowingly and willfully bills an individual enrolled under this part for charges that includes a charge for an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2)."

42 USC 1395y
note.

(d) **EXTENSION OF PROHIBITION TO OTHER PROCEDURES.**—The Secretary of Health and Human Services, after consultation with the Physician Payment Review Commission, shall develop recommendations and guidelines respecting other surgical procedures for which an assistant at surgery is generally not medically necessary and the circumstances under which the use of an assistant at surgery is generally appropriate but should be subject to prior approval of an appropriate entity. The Secretary shall report to Congress, not later than January 1, 1987, on these recommendations and guidelines.

42 USC 1320c-3
note.

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services performed on or after April 1, 1986.

Subpart B—Benefits and Other Provisions

SEC. 9313. PART B PREMIUM.

Section 1839 of the Social Security Act (42 U.S.C. 1395r) is amended—

(1) in subsection (e), by striking out "1988" and inserting in lieu thereof "1989" each place it appears;

(2) in subsection (f)(1), by striking out "or 1986" and inserting in lieu thereof ", 1986, or 1987"; and

(3) in subsection (f)(2), by striking out "or 1987" and inserting in lieu thereof ", 1987, or 1988".

SEC. 9314. DEMONSTRATION OF PREVENTIVE HEALTH SERVICES UNDER MEDICARE.

42 USC 1395b-1
note.

(a) **DEMONSTRATION PROGRAM.**—The Secretary of Health and Human Services (hereinafter in this section referred to as the "Secretary") shall establish a 4-year demonstration program designed to reduce disability and dependency through the provision of preventive health services to individuals entitled to benefits under title XVIII of the Social Security Act (hereinafter in this section referred to as "medicare beneficiaries").

42 USC 1395c.

(b) **PREVENTIVE HEALTH SERVICES UNDER DEMONSTRATION PROGRAM.**—The preventive health services to be made available under the demonstration program shall include—

- (1) health screenings,
- (2) health risk appraisals,
- (3) immunizations, and

(4) counseling on and instruction in—

- (A) diet and nutrition,
- (B) reduction of stress,
- (C) exercise and exercise programs,
- (D) sleep regulation,
- (E) injury prevention,
- (F) prevention of alcohol and drug abuse,
- (G) prevention of mental health disorders,
- (H) self-care, including use of medication, and
- (I) reduction or cessation of smoking.

(c) CONDUCT OF PROGRAM.—The demonstration program shall—

Schools and colleges.

(1) be conducted under the direction of accredited public or private nonprofit schools of public health or preventive medicine departments accredited by the Council on Education for Public Health;

(2) be conducted in no fewer than five sites, which sites shall be chosen so as to be geographically diverse and shall be readily accessible to a significant number of medicare beneficiaries;

(3) involve community outreach efforts at each site to enroll the maximum number of medicare beneficiaries in the program; and

(4) be designed—

(A) to test alternative methods of payment for preventive health services, including payment on a prepayment basis as well as payment on a fee-for-service basis,

(B) to permit a variety of appropriate health care providers to furnish preventive health services, including physicians, health educators, nurses, allied health personnel, dieticians, and clinical psychologists, and

(C) to facilitate evaluation under subsection (d).

(d) EVALUATION.—The Secretary shall evaluate the demonstration project in order to determine—

(1) the short-term and long-term costs and benefits of providing preventive health services for medicare beneficiaries, including any reduction in inpatient services resulting from providing the services, and

(2) what practical mechanisms exist to finance preventive health services under title XVIII of the Social Security Act.

42 USC 1395c.

(e) REPORTS TO CONGRESS.—(1) Not later than three years after the date of the enactment of this Act, the Secretary shall submit a preliminary report to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and to the Committee on Finance of the Senate on the progress made in the demonstration program, including a description of the sites at which the program is being conducted and the preventive health services being provided at the different sites.

(2) Not later than five years after the date of the enactment of this Act, the Secretary shall submit a final report to those Committees on the demonstration program and shall include in the report—

(A) the evaluation described in subsection (d), and

(B) recommendations for appropriate legislative changes to incorporate payment for cost-effective preventive health services into the medicare program.

(f) FUNDING.—Expenditures made for the demonstration program shall be made from the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in ad-

42 USC 1395t.

vance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section. Funding for the demonstration program shall not exceed \$4,000,000 over the duration of the program.

42 USC 1395c. (g) **WAIVER OF MEDICARE REQUIREMENTS.**—The Secretary shall waive compliance with such requirements of title XVIII of the Social Security Act to the extent and for the period the Secretary finds necessary for the conduct of the demonstration program.

SEC. 9315. EXTENSION OF GAO REPORTING DATE.

42 USC 1395h note. (a) **EXTENSION.**—Section 2326(e)(2) of the Deficit Reduction Act of 1984 (98 Stat. 1088) is amended by striking out “12 months after the date of the enactment of this Act” and inserting in lieu thereof “May 1, 1986”.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall apply as though it were included in the Deficit Reduction Act of 1984 as originally enacted.

PART 4—PEER REVIEW ORGANIZATIONS

SEC. 9401. 100 PERCENT PEER REVIEW OF CERTAIN SURGICAL PROCEDURES.

42 USC 1320c-3. (a) **REQUIREMENT.**—Section 1154(a) of the Social Security Act (42 U.S.C. 1395c-3(a)) is amended by adding at the end thereof the following new paragraph:

Infra. “(12) The organization shall perform the review, referral, and other functions required under section 1164.”.

(b) **ADDITIONAL PEER REVIEW FUNCTIONS.**—Part B of title XI of the Social Security Act is amended by adding at the end the following new section:

“100 PERCENT PEER REVIEW FOR CERTAIN SURGICAL PROCEDURES

42 USC 1320c-13. “SEC. 1164. (a) 100 PERCENT REVIEW FUNCTION.—

“**(1) IN GENERAL.**—Each utilization and quality control peer review organization shall perform the review described in section 1154(a)(1) for 100 percent of the surgical procedures specified pursuant to subsection (b).

“**(2) TIMING OF REVIEW.**—

“**(A) IN GENERAL.**—Except as provided in subparagraph (B), the review required under paragraph (1) shall be performed—

“(i) before the performance of the procedure, in the case of an outpatient procedure, or

“(ii) before admission to the hospital for the provision of services in connection with the procedure, in the case of a procedure performed on an inpatient basis.

“**(B) EXCEPTION.**—The review with respect to a procedure need not be performed by the time specified in subparagraph (A) in cases of a medical emergency and under such other circumstances as the Secretary may specify.

“(b) **SPECIFICATION OF SURGICAL PROCEDURES AND QUALIFIED REVIEWERS.**—

“(1) **IN CONTRACT.**—The contract with each organization under this part shall specify at least 10 surgical procedures to be covered under this section.

“(2) SELECTION GUIDELINES.—

“(A) IN GENERAL.—The specification of procedures shall be consistent with selection guidelines established by the Secretary under paragraph (3). The procedures specified shall be included among the surgical procedures which the Secretary has identified as reasonably being able to meet such guidelines.

“(B) EXCEPTION.—The Secretary may permit an organization to include among the procedures specified under paragraph (1) procedures not identified by the Secretary under paragraph (2)(A) if to do so would be cost effective and consistent with the criteria described in paragraph (3).

“(3) CRITERIA.—The Secretary shall establish such guidelines and identify such surgical procedures consistent with the following criteria:

“(A) The procedure is one which generally can be postponed without undue risk to the patient.

“(B) The procedure is a high volume procedure among patients who are covered under the programs established under title XVIII or is a high cost procedure.

“(C) The procedure has a comparatively high rate of nonconfirmation upon examination by another qualified physician, there is substantial geographic variation in the rates of performance of the procedure, or there are other reasons why pre-procedure review for 100 percent of the procedures would be cost effective.

42 USC 1395c.

“(4) QUALIFICATIONS FOR PHYSICIANS PROVIDING SECOND OPINIONS.—

“(A) IN GENERAL.—The Secretary shall specify, for each procedure identified under paragraphs (2) and (3), the type or types of board certified or board eligible specialists who may conduct a second opinion, required under subsection (c), based upon the nature of the procedure.

“(B) FREEDOM OF CHOICE OF PATIENT TO CHOOSE PHYSICIAN.—Subject to paragraphs (C) and (D), the patient may choose any physician of the proper specialty under subparagraph (A) to provide the second opinion.

“(C) PHYSICIANS PROHIBITED FROM PROVIDING SECOND OPINIONS.—For purposes of this section, a second opinion may not be provided by a physician who is affiliated with, or has a common financial interest with, the physician who rendered the first opinion that the procedure was necessary.

“(D) RESTRICTED LIST.—In accordance with guidelines of the Secretary, an organization may disqualify a physician from providing a second opinion under this section because of the gross unreliability of the second opinions provided.

“(c) REQUIRING A SECOND OPINION IN CERTAIN CASES.—

“(1) DETERMINATIONS BY ORGANIZATION.—In the case of a review performed pursuant to subsection (a), the organization shall determine, based on such review, that the surgical procedure—

“(A) is reasonable and medically necessary,

“(B) is not reasonable and medically necessary, or

“(C) may be considered reasonable and necessary, but, because of questions as to the medical appropriateness of performing the procedure, it is appropriate to require the patient to seek a second opinion as to the necessity and

appropriateness of performing the procedure before the performance of the procedure.

The Secretary shall develop appropriate measures to ensure that second opinions are only required in situations where a second opinion is needed to resolve outstanding uncertainties as to the medical necessity of the procedure. The organization shall notify, in accordance with section 1154(a)(3), the physician, patient, and hospital or other entity furnishing the service, in the event of a determination under subparagraph (B) or (C) of this paragraph.

42 USC 1320c-3.

42 USC 1395c,
1395j.

“(2) PROHIBITION OF PAYMENT IF REQUIRED SECOND OPINION NOT PROVIDED.—No payment may be made under part A or part B of title XVIII with respect to items or services furnished in connection with a surgical procedure for which there is a determination described in paragraph (1)(C), unless the individual undergoing the procedure obtains the second opinion required under that paragraph. The second opinion need not necessarily agree with the first opinion in order for payment to be made.

“(3) EXCEPTIONS FOR ELECTIVE SECOND OPINIONS.—Paragraphs (1)(C) and (2) shall not apply to a surgical procedure if—

“(A) a delay in providing the procedure would result in a risk to the patient;

“(B) no physician is available (within such reasonable limits as the Secretary shall specify) who is (i) qualified to provide the second opinion, and (ii) a participating physician or a physician who has agreed to accept assignment for the second opinion; or

“(C) the procedure is to be performed on a patient who is a member of a health maintenance organization or competitive medical plan having a risk-sharing contract with the Secretary under section 1876.

42 USC 1395mm.

“(d) REFERRAL MECHANISM FOR SECOND OPINIONS.—

“(1) ACTING AS REFERRAL CENTER.—Each organization shall serve as a referral center for second opinions required under this section.

“(2) REFERRAL OF PATIENT.—The organization shall maintain a list of physicians qualified to provide a second opinion and shall advise the patient as to which physicians are participating physicians (within the meaning of section 1842(h)) and which physicians have agreed to accept assignment to perform second opinions. The organization shall assist patients in referral to a qualified physician of the appropriate specialty for purposes of providing the opinion.

42 USC 1395u.

“(3) FORWARDING OF RELEVANT MEDICAL RECORDS.—Each peer review organization shall, if the patient seeking the second opinion so requests, obtain the relevant medical records from the physician who rendered the first opinion that the procedure was necessary, and provide the relevant information to the physician selected by the patient to render the second opinion.

“(e) NOTICE TO PHYSICIANS, HOSPITALS, AND BENEFICIARIES.—The Secretary shall assure that notice is provided to physicians, hospitals, ambulatory surgical centers, and beneficiaries respecting the activities under this section, including the applicable list of surgical procedures specified under this section.”

(b) WAIVER OF DEDUCTIBLE AND COPAYMENTS.—

(1) DEDUCTIBLE.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended by striking out “and” before “(4)”,

42 USC 1395l.

and by inserting before the period at the end of the first sentence the following: “, and (5) such deductible shall not apply with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)”.

Ante, p. 196.

(2) **COPAYMENTS.**—(A) Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) is amended by striking out “and” before “(F)”, and by adding at the end thereof the following: “and (G) with respect to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), the amounts paid shall be 100 percent of the reasonable charges for such items and services;”.

42 USC 1395l.

(B) Section 1833(a)(1)(D) of such Act is amended by striking out “or under the procedure described in section 1870(f)(1)” and inserting in lieu thereof “, under the procedure described in section 1870(f)(1), or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)”.

42 USC 1395gg.

(C) Section 1833(a)(2)(A) of such Act is amended by inserting “, to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion),” after “(other than durable medical equipment)”.

(D) Section 1833(a)(2)(D) of such Act is amended by striking out “or to a provider having an agreement under section 1866” and inserting in lieu thereof “to a provider having an agreement under section 1866, or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion)”.

(E) Section 1833(a)(3) of such Act is amended by inserting after “1861(s)(10)(A)” the following: “and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion”.

(F) The last sentence of section 1866(a)(2)(A) of such Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting after “1861(s)(10)(A)” the following: “, with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion),”.

(c) **CONFORMING AMENDMENTS.**—

(1) **EXCLUSIONS FROM COVERAGE.**—Section 1862(a) of the Social Security Act (42 U.S.C. 1395g(a)), as amended by section 9307(a) of this title, is amended—

42 USC 1395y.

(A) by striking out “or” at the end of paragraph (14);

(B) by striking out the period at the end of paragraph (15) and inserting in lieu thereof “; or”; and

(C) by adding at the end thereof the following new paragraph:

“(16) furnished in connection with a surgical procedure for which a second opinion is required under section 1164(c)(2) and has not been obtained.”.

42 USC 1320c-3
note.

Contracts.

42 USC 1320c.

42 USC 1320c-13
note.

(d) **EFFECTIVE DATES.**—The amendments made by subsection (a) shall apply to items and services furnished on or after January 1, 1987. The Secretary of Health and Human Services shall provide for such modification of contracts under part B of title XI of the Social Security Act that are in effect on that date as may be necessary to effect these amendments on a timely basis.

(e) **STUDY.**—The Secretary of Health and Human Services shall conduct a study of the results of the amendments made by this section, and shall report the results of the study to the Congress within 36 months after the date of the enactment of this Act.

SEC. 9402. PEER REVIEW ORGANIZATION REIMBURSEMENT.

(a) **REIMBURSEMENT AMOUNTS.**—Section 1866(a)(1)(F) of the Social Security Act (42 U.S.C. 1395cc(a)(1)(F)) is amended—

(1) by striking out clause (iii),

(2) by inserting “and” at the end of clause (ii),

(3) by redesignating clause (iv) as clause (iii), and

(4) by striking out “1982” in clause (iii) as so redesignated and inserting in lieu thereof “1986”.

(b) **MONTHLY PAYMENTS.**—Section 1153(c)(8) of such Act (42 U.S.C. 1320c-2(c)(8)) is amended to read as follows:

“(8) reimbursement shall be made to the organization on a monthly basis, with payments for any month being made not later than 15 days after the close of such month.”.

42 USC 1395cc
note.

42 USC 1320c-2
note.

(c) **EFFECTIVE DATES.**—(1) The amendments made by subsection (a) shall become effective on the date of the enactment of this Act.

(2) The amendment made by subsection (b) shall apply to contracts entered into or renewed on or after the date of the enactment of this Act.

SEC. 9403. DENIAL OF PAYMENT FOR SUBSTANDARD CARE.

(a) **DENIAL AUTHORITY FOR PRO.**—Section 1154(a)(2) of the Social Security Act (42 U.S.C. 1320c-3(a)(2)) is amended—

(1) by striking out “subparagraphs (A) and (C)” and inserting in lieu thereof “subparagraphs (A), (B), and (C)”; and

(2) by adding at the end thereof (after and below subparagraph (D)) the following:

“Determinations that payment should not be made by reason of subparagraph (B) of paragraph (1) shall be made only on the basis of criteria which are consistent with guidelines established by the Secretary.”.

(b) **WAIVER OF LIABILITY.**—Section 1866(a)(1) of such Act (42 U.S.C. 1395cc(a)(1)) is amended by striking out “and” at the end of subparagraph (G), by striking out the period at the end of subparagraph (H) and inserting in lieu thereof “, and”, and by inserting after subparagraph (H) the following new subparagraph:

“(I) not to charge any individual or any other person for items or services for which payment under this title is denied under section 1154(a)(2) by reason of a determination under section 1154(a)(1)(B).”.

42 USC 1320c-3
note.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall become effective on the date of the enactment of this Act.

SEC. 9404. HEALTH MAINTENANCE ORGANIZATION MEMBERSHIP ON PEER REVIEW ORGANIZATION BOARDS.

(a) **REMOVAL OF ONE-MEMBER LIMITATION.**—Section 1153(b)(2)(A) of the Social Security Act (42 U.S.C. 1320c-2(b)(2)(A)) is amended by

striking out “consists only of one individual member of the governing board” and inserting in lieu thereof “consists only of members of the governing board”.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall become effective on the date of the enactment of this Act.

42 USC 1320c-2
note.

SEC. 9405. PEER REVIEW ORGANIZATION REVIEW OF HEALTH MAINTENANCE ORGANIZATIONS.

(a) **COMPARABLE REVIEW FOR HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.**—Section 1154(a)(1) of the Social Security Act (42 U.S.C. 1320c-3(a)(1)) is amended by inserting “(including where payment is made for such services to eligible organizations pursuant to contracts under section 1876)” after “title XVIII”.

42 USC 1395mm.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall apply to items and services furnished on or after January 1, 1987.

42 USC 1320c-3
note.

SEC. 9406. SUBSTITUTE REVIEW PENDING TERMINATION OF A PEER REVIEW ORGANIZATION CONTRACT.

(a) **SUBSTITUTE REVIEW.**—Section 1153(d) of the Social Security Act (42 U.S.C. 1320c-2(d)) is amended by adding at the end thereof the following new paragraph:

“(4) During the period after the Secretary has given notice of intent to terminate a contract, and prior to the time that the Secretary enters into a contract with another utilization and quality control peer review organization, the Secretary may transfer review responsibilities of the organization under the contract being terminated to another utilization and quality control peer review organization, or to an intermediary or carrier having an agreement under section 1816 or a contract under section 1842.”.

(b) **EFFECTIVE DATE.**—The amendment made by this section shall become effective on the date of the enactment of this Act.

42 USC 1395h,
1395u.
42 USC 1320c-2
note.

Subtitle B—Medicaid and Maternal and Child Health

SEC. 9501. SERVICES FOR PREGNANT WOMEN.

(a) **EXPANDED COVERAGE.**—Section 1905(n)(1) of the Social Security Act (42 U.S.C. 1396d(n)(1)) is amended—

- (1) by striking out “or” at the end of subparagraph (A);
- (2) by striking out “and” at the end of subparagraph (B) and inserting in lieu thereof “or”; and
- (3) by adding after subparagraph (B) the following new subparagraph:

“(C) otherwise meets the income and resources requirements of a State plan under part A of title IV; and”.

(b) **OPTIONAL EXPANSION OF PREGNANCY-RELATED SERVICES.**—Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended, in the matter after subparagraph (D) thereof—

- (1) by striking out “and” before “(IV)” and inserting in lieu thereof a comma; and
- (2) by inserting before the semicolon at the end thereof the following: “, and (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other

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42 USC 601.

condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan”.

42 USC 1396a.

State and local government.

(c) **POSTPARTUM ELIGIBILITY FOR PREGNANT WOMEN.**—Section 1902(e) of such Act (42 U.S.C. 1396b(e)) is amended by adding at the end the following new paragraph:

“(5) A woman who, while pregnant, is eligible for, has applied for, and has received medical assistance under the State plan, shall continue to be eligible under the plan, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan, until the end of the 60-day period beginning on the last day of her pregnancy.”.

(d) **EFFECTIVE DATES.**—

42 USC 1396d note.

42 USC 1396.

State and local government.

(1) **EXPANDED COVERAGE.**—(A) The amendments made by subsection (a) apply (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after the July 1, 1986, without regard to whether or not final regulations to carry out the amendments have been promulgated by that date.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

42 USC 1396a note.

42 USC 1396a note.

(2) **OPTIONAL SERVICES.**—The amendments made by subsection (b) shall become effective on the date of the enactment of this Act.

(3) **CONTINUED COVERAGE.**—The amendment made by subsection (c) shall apply to medical assistance furnished to a woman on or after the date of the enactment of this Act.

SEC. 9502. MODIFICATIONS OF WAIVER PROVISIONS FOR HOME AND COMMUNITY-BASED SERVICES.

(a) **EXPLICIT INCLUSION OF CERTAIN PREVOCAATIONAL AND EDUCATIONAL SERVICES.**—Section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) is amended by adding at the end thereof the following new paragraph:

“(5) For purposes of paragraph (4)(B), the term ‘habilitation services’, with respect to individuals who receive such services after discharge from a skilled nursing facility or intermediate care facility—

“(A) means services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings; and

“(B) includes (except as provided in subparagraph (C)) prevocational, educational, and supported employment services; but

“(C) does not include—

“(i) special education and related services (as defined in section 602(16) and (17) of the Education of the Handicapped Act (20 U.S.C. 1401(16), (17)) which otherwise are available to the individual through a local educational agency; and

“(ii) vocational rehabilitation services which otherwise are available to the individual through a program funded under section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).”.

(b) **PERMITTING HOSPITAL LEVEL OF CARE FOR CERTAIN PARTICIPANTS.**—(1) Section 1915(c)(1) of such Act (42 U.S.C. 1396n(c)(1)) is amended by inserting “or but for the provision of such services the individuals would continue to receive inpatient hospital services, skilled nursing facility services, or intermediate care facility services because they are dependent on ventilator support the cost of which is reimbursed under the State plan” before the period at the end thereof.

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(2) Section 1915(c)(2)(C) of such Act (42 U.S.C. 1396n(c)(2)(C)) is amended—

(A) by inserting “hospital or” after “provided in a”; and

(B) by inserting “inpatient hospital services or” after “the provision of”.

(c) **PROHIBITING IMPOSITION OF CERTAIN REGULATORY LIMITS.**—Section 1915(c) of such Act (42 U.S.C. 1396n(c)) as amended by subsection (a), is further amended—

(1) in paragraph (2)(D), by inserting “100 percent of” after “does not exceed”; and

(2) by adding at the end thereof the following new paragraph:

“(6) The Secretary may not require, as a condition of approval of a waiver under this section under paragraph (2)(D), that the actual total expenditures for home and community-based services under the waiver (and a claim for Federal financial participation in expenditures for the services) cannot exceed the approved estimates for these services. The Secretary may not deny Federal financial payment with respect to services under such a waiver on the ground that, in order to comply with paragraph (2)(D), a State has failed to comply with such a requirement.”.

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(d) **COMPUTATION OF EXPENDITURES FOR CERTAIN DISABLED PATIENTS.**—Section 1915(c) of such Act (42 U.S.C. 1396n(c)), as amended by subsection (c), is further amended by adding at the end thereof the following new paragraph:

“(7) In making estimates under paragraph (2)(D) in the case of a waiver which applies only to physically disabled individuals who are inpatients in skilled nursing or intermediate care facilities, the State may determine the average per capita expenditure which would have been made in a fiscal year for those individuals under the State plan separately from the expenditure for other individuals who are inpatients of those facilities.”.

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(e) **PERMITTING FLEXIBILITY IN ESTABLISHING MAINTENANCE INCOME STANDARDS.**—Section 1915(c)(3) of such Act (42 U.S.C. 1396n(c)(3)) is amended by adding at the end the following new sentence: “A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which

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42 USC 1396n
note.

may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.”

(f) **WAIVER EXTENSIONS.**—The Secretary of Health and Human Services shall extend, upon request of the State, any waiver under section 1915(c) of the Social Security Act which expires on or after September 30, 1985, and before September 30, 1986. Such extension shall be for a period of not less than one year nor more than five years, subject to section 1915(e)(1) of such Act.

(g) **WAIVER RENEWALS.**—Section 1915(c)(3) of the Social Security Act (42 U.S.C. 1396n(c)(3)) is amended—

(1) by striking out “additional three-year periods” and inserting in lieu thereof “additional five-year periods”; and

(2) by striking out “previous three-year period” and inserting in lieu thereof “previous waiver period”.

(h) **COORDINATED SERVICES BETWEEN MCH PROGRAM AND HOME AND COMMUNITY-BASED SERVICE PROGRAMS.**—Section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), as amended by subsection (d) of this section, is further amended by adding at the end thereof the following new paragraph:

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42 USC 701.

“(8) The State agency administering the plan under this title may, whenever appropriate, enter into cooperative arrangements with the State agency responsible for administering the program for children with special health care needs under title V in order to assure improved access to coordinated services to meet the needs of such children.”.

(i) **SUBSTITUTION OF PARTICIPANTS.**—(1) Section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), as amended by subsection (h) of this section, is further amended by adding at the end thereof the following new paragraph:

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“(9) In the case of any waiver under this subsection which contains a limit on the number of individuals who shall receive home or community-based services, the State may substitute additional individuals to receive such services to replace any individuals who die or become ineligible for services under the State plan.”.

42 USC 1396n
note.

(j) **EFFECTIVE DATES.**—

(1) **HABILITATION SERVICES.**— The amendment made by subsection (a) shall be effective for services furnished on or after the date of the enactment of this Act.

(2) **HOSPITALIZED PATIENTS.**—The amendments made by subsection (b) shall be effective for services furnished on or after October 1, 1985.

(3) **PROHIBITION OF REGULATORY LIMITS AND TREATMENT OF CERTAIN PHYSICALLY DISABLED INDIVIDUALS.**—The amendments made by subsections (c) and (d) shall apply to applications for waivers (or renewals thereof) filed before, on, or after, the date of the enactment of this Act and for services furnished on or after August 13, 1981.

(4) **INCOME STANDARDS.**—The amendment made by subsection (e) shall apply to waivers (or renewals thereof) approved on or after the date of the enactment of this Act.

(5) **WAIVER EXTENSIONS.**—Subsection (f) shall apply to waivers expiring on or after September 30, 1985, and before September 30, 1986.

(6) **WAIVER RENEWALS.**—The amendments made by subsection (g) shall become effective on September 30, 1986.

(7) **COORDINATED SERVICES AND SUBSTITUTION OF PARTICIPANTS.**—The amendments made by subsections (h) and (i) shall become effective on the date of the enactment of this Act.

SEC. 9503. THIRD-PARTY LIABILITY.

(a) **AMENDMENTS TO STATE PLAN REQUIREMENTS.**—(1) Section 1902(a)(25) of the Social Security Act (42 U.S.C. 1396a(a)(25)) is amended to read as follows:

“(25) provide—

“(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers) to pay for care and services available under the plan, including—

“(i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

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“(ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall—

“(I) be integrated with, and be monitored as a part of the Secretary’s review of, the State’s mechanized claims processing and information retrieval system under section 1903(r), and

42 USC 1396b.

“(II) be subject to the provisions of section 1903(r)(4) relating to reductions in Federal payments for failure to meet conditions of approval, but shall not be subject to any other financial penalty as a result of any other monitoring, quality control, or auditing requirements;

“(B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;

“(C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 1916), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 1916, or (II) the amount by which the amount payable for that service under the plan (disregarding section 1916) exceeds the total of the amount of the liabilities of third parties for that service;

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42 USC 1396o.

“(D) that a person who furnishes services and is participating under the plan may not refuse to furnish services to

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an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service; "(E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1905(a)(4)(B)) covered under the State plan, the State shall—

"(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and

"(ii) seek reimbursement from such third party in accordance with subparagraph (B); and

"(F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of title IV of this Act, the State shall—

"(i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and

"(ii) seek reimbursement from such third party in accordance with subparagraph (B);".

(2) Section 1902 of such Act (42 U.S.C. 1396a) is amended by inserting after subsection (f) the following new subsection:

"(g) In addition to any other sanction available to a State, a State may provide for a reduction of any payment amount otherwise due with respect to a person who furnishes services under the plan in an amount equal to up to three times the amount of any payment sought to be collected by that person in violation of subsection (a)(25)(C).".

(b) PERFORMANCE STANDARDS AND REVIEW FOR MECHANIZED CLAIMS PROCESSING AND INFORMATION RETRIEVAL SYSTEMS.—(1) Section 1903(r)(6)(J) of such Act (42 U.S.C. 1396b(r)(6)(J)) is amended to read as follows:

"(J) develop and disseminate performance standards for assessing the State's third party collection efforts in accordance with section 1902(a)(25)(A)(ii).".

(2) Section 1903(r)(4)(A) of such Act (42 U.S.C. 1396b(r)(4)(A)) is amended—

(A) by striking out "once each fiscal year" and inserting in lieu thereof "once every three years"; and

(B) by adding at the end thereof the following: "Reviews may, at the Secretary's discretion, constitute reviews of the entire system or of only those standards, systems requirements, and other conditions which have demonstrated weakness in previous reviews.".

(c) REGULATIONS.—The Secretary of Health and Human Services shall promulgate final regulations necessary to carry out sections 1902(a)(25) and 1903(r)(6)(J) of the Social Security Act within 6 months after the date of the enactment of this Act.

42 USC 1396d.

42 USC 651.

42 USC 1396a
note.

(d) **ERISA AMENDMENT.**—(1) Section 514(b) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) is amended by adding at the end thereof the following new paragraph:

“(8) Subsection (a) of this section shall not apply to any State law mandating that an employee benefit plan not include any provision which has the effect of limiting or excluding coverage or payment for any health care for an individual who would otherwise be covered or entitled to benefits or services under the terms of the employee benefit plan, because that individual is provided, or is eligible for, benefits or services pursuant to a plan under title XIX of the Social Security Act, to the extent such law is necessary for the State to be eligible to receive reimbursement under title XIX of that Act.”.

Prohibition.

42 USC 1396.

(2)(A) Except as provided in subparagraph (B), the amendment made by paragraph (1) shall become effective on October 1, 1986.

29 USC 1144

note.
Effective dates.

(B) In the case of a plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified on or before the date of the enactment of this Act, the amendment made by paragraph (1) shall become effective on the later of—

(i) October 1, 1986; or

(ii) the earlier of—

(I) the date on which the last of the collective bargaining agreements under which the plan is maintained, which were in effect on the date of the enactment of this Act, terminates (determined without regard to any extension thereof agreed to after the date of the enactment of this Act); or

(II) three years after the date of the enactment of this Act.

(e) **CONDITION OF ELIGIBILITY.**—Section 1912(a)(1) of the Social Security Act (42 U.S.C. 1396k(a)(1)) is amended by striking out “and” at the end of subparagraph (A), and by adding at the end thereof the following new subparagraph:

“(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; and”.

(f) **DISREGARD FROM ERRONEOUS PAYMENTS.**—Section 1903(u)(1)(D) of such Act (42 U.S.C. 1396b(u)(1)(D)) is amended by adding at the end thereof the following new clause:

“(iv) In determining the amount of erroneous excess payments, there shall not be included any error resulting from a failure of an individual to cooperate or give correct information with respect to third-party liability as required under section 1912(a)(1)(C) or 402(a)(26)(C).”.

42 USC 602.
42 USC 1396a
note.

(g) **EFFECTIVE DATES.**—(1) Except as otherwise provided, the amendments made by this section shall apply to calendar quarters beginning on or after the date of the enactment of this Act.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the

additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

Prohibition.
42 USC 1396a.

(3) No penalty may be applied against any State for a violation of section 1902(a)(25) of the Social Security Act occurring prior to the effective date of the amendments made by this section.

(4) The amendment made by subsection (c) shall become effective on the date of the enactment of this Act.

SEC. 9505. OPTIONAL HOSPICE BENEFITS.

(a) **COVERAGE OF HOSPICE CARE AS AN OPTIONAL MEDICAID BENEFIT.**—Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended—

(1) in subsection (a)—

(A) by striking out “and” at the end of paragraph (17);

(B) by redesignating paragraph (18) as paragraph (19); and

(C) by inserting after paragraph (17) the following new paragraph:

“(18) hospice care (as defined in subsection (o)); and”; and

(2) by adding at the end thereof the following new subsection:

42 USC 1395x.

“(o)(1) The term ‘hospice care’ means the care described in section 1861(dd)(1) furnished by a hospice program (as defined in section 1861(dd)(2)) to a terminally ill individual who has voluntarily elected (in accordance with paragraph (2)) to have payment made for hospice care instead of having payment made for certain benefits described in section 1812(d)(2)(A) and intermediate care facility services under the plan. For purposes of such election, hospice care may be provided to an individual while such individual is a resident of a skilled nursing facility or intermediate care facility, but the only payment made under the State plan shall be for the hospice care.

42 USC 1395d.

“(2) An individual’s voluntary election under this subsection—

“(A) shall be made in accordance with procedures that are established by the State and that are consistent with the procedures established under section 1812(d)(2);

“(B) shall be for such a period or periods (which need not be the same periods described in section 1812(d)(1)) as the State may establish; and

“(C) may be revoked at any time without a showing of cause and may be modified so as to change the hospice program with respect to which a previous election was made.”.

(b) **ELIGIBILITY.**—

(1) **LIMITATION TO TERMINALLY ILL INDIVIDUALS.**—Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)), as amended by section 9501 of this Act, is further amended, in the matter following subparagraph (D), by striking out “and” before “(V)” and by inserting before the semicolon at the end thereof the following: “, and (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under title

XVIII, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals". 42 USC 1395c.

(2) **HIGHER INCOME STANDARD PERMITTED.**—Section 1902(a)(10)(A)(ii) of such Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(A) by striking out "or" at the end of subclause (V);
(B) by striking out the semicolon at the end of subclause (VI) and inserting in lieu thereof "or"; and

(C) by adding at the end the following new subclause:
"(VII) who would be eligible under the State plan under this title if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1905(o);".

42 USC 1396d.

(c) **PAYMENT FOR HOSPICE CARE.**—

(1) **USE OF MEDICARE RATES.**—Section 1902(a)(13) of such Act (42 U.S.C. 1396a(a)(13)) is amended—

(A) by striking out "and" at the end of subparagraph (B);
(B) by redesignating subparagraph (C) as subparagraph (D); and

(C) by inserting after subparagraph (B) the following new subparagraph:

"(C) for payment for hospice care in the same amounts, and using the same methodology, as used under part A of title XVIII; except that a separate rate may be paid for hospice care which is furnished to an individual who is a resident of a skilled nursing facility or intermediate care facility, and who would be eligible under the plan for skilled nursing facility services or intermediate care facility services if he had not elected to receive hospice care, to take into account the room and board furnished by such facility; and".

42 USC 1395c.

(2) **LIMITATION ON COPAYMENTS.**—Subsections (a)(2) and (b)(2) of section 1916 of the Social Security Act (42 U.S.C. 1396o) are each amended—

(A) by striking out "or" at the end of subparagraph (C);
(B) by striking out "and" at the end of subparagraph (D) and inserting in lieu thereof "or"; and

(C) by adding at the end the following new subparagraph:
"(E) services furnished to an individual who is receiving hospice care (as defined in section 1905(o)); and".

(d) **CONFORMING AMENDMENTS.**—

(1) Section 1902(j) of such Act (42 U.S.C. 1396a(j)) is amended by striking out "(18)" and inserting in lieu thereof "(19)".

(2) Section 1902(a)(10)(C)(iv) of such Act (42 U.S.C. 1396a(a)(10)(C)(iv)) is amended by striking out "through (17)" and inserting in lieu thereof "through (18)".

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply to medical assistance provided for hospice care furnished on or after the date of the enactment of this Act.

42 USC 1396a
note.

SEC. 9506. TREATMENT OF POTENTIAL PAYMENTS FROM MEDICAID QUALIFYING TRUSTS.

(a) **AMOUNTS TREATED AS BEING AVAILABLE FROM GRANTOR TRUSTS.**—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended by adding at the end thereof the following new subsection:

“(k)(1) In the case of a medicaid qualifying trust (described in paragraph (2)), the amounts from the trust deemed available to a grantor, for purposes of subsection (a)(17), is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the grantor, assuming the full exercise of discretion by the trustee or trustees for the distribution of the maximum amount to the grantor. For purposes of the previous sentence, the term ‘grantor’ means the individual referred to in paragraph (2).

“(2) For purposes of this subsection, a ‘medicaid qualifying trust’ is a trust, or similar legal device, established (other than by will) by an individual (or an individual’s spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

“(3) This subsection shall apply without regard to—

“(A) whether or not the medicaid qualifying trust is irrevocable or is established for purposes other than to enable a grantor to qualify for medical assistance under this title; or

“(B) whether or not the discretion described in paragraph (2) is actually exercised.

“(4) The State may waive the application of this subsection with respect to an individual where the State determines that such application would work an undue hardship.”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to medical assistance furnished on or after the first day of the second month beginning after the date of the enactment of this Act.

SEC. 9507. WRITTEN STANDARDS FOR PROVISION OF ORGAN TRANSPLANTS.

(a) **DENIAL OF FEDERAL PAYMENTS FOR ORGAN TRANSPLANTS UNLESS PROVIDED UNDER WRITTEN STANDARDS.**—Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended by inserting before paragraph (2) the following new paragraph:

“(1) for organ transplant procedures unless the State plan provides for written standards respecting the coverage of such procedures and unless such standards provide that—

“(A) similarly situated individuals are treated alike; and

“(B) any restriction, on the facilities or practitioners which may provide such procedures, is consistent with the accessibility of high quality care to individuals eligible for the procedures under the State plan.”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to medical assistance furnished on or after January 1, 1987.

SEC. 9508. OPTIONAL TARGETED CASE MANAGEMENT SERVICES.

(a) **EXEMPTION FROM CERTAIN REQUIREMENTS.**—(1) Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended by adding at the end thereof the following new subsection:

State and local governments.

42 USC 1396a note.

42 USC 1396b note.

“(g)(1) A State may provide, as medical assistance, case management services under the plan without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B). The provision of case management services under this subsection shall not restrict the choice of the individual to receive medical assistance in violation of section 1902(a)(23).

State and local governments.
42 USC 1396a.

“(2) For purposes of this subsection, the term ‘case management services’ means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.”.

(2) Section 1915(b) of such Act (42 U.S.C. 1396n(b)) is amended by adding at the end thereof (after and below paragraph (4)) the following: “No waiver under this subsection may restrict the choice of the individual in receiving services under section 1905(a)(4)(C).”.

42 USC 1396d.
42 USC 1396n
note.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished on or after the date of the enactment of this Act.

SEC. 9509. REVALUATION OF ASSETS.

(a) **REVALUATION OF ASSETS.**—Section 1902(a)(13) of the Social Security Act (42 U.S.C. 1396a(a)(13)), as amended by section 9505 of this Act, is further amended—

(1) in subparagraph (B), by striking out “hospitals, skilled nursing facilities, and intermediate care facilities” and inserting in lieu thereof “hospitals”;

(2) by striking out “and” at the end of subparagraph (C);

(3) by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E); and

(4) by inserting after subparagraph (B) the following new subparagraph:

“(C) that the State shall provide assurances satisfactory to the Secretary that the valuation of capital assets, for purposes of determining payment rates for skilled nursing facilities and intermediate care facilities, will not be increased (as measured from the date of acquisition by the seller to the date of the change of ownership), solely as a result of a change of ownership, by more than the lesser of—

State and local governments.

“(i) one-half of the percentage increase (as measured over the same period of time, or, if necessary, as extrapolated retrospectively by the Secretary) in the Dodge Construction Systems Costs for Nursing Homes, applied in the aggregate with respect to those facilities which have undergone a change of ownership during the fiscal year, or

“(ii) one-half of the percentage increase (as measured over the same period of time) in the Consumer Price Index for All Urban Consumers (United States city average);”.

(b) **EFFECTIVE DATES.**—(1) Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply to medical assistance furnished on or after October 1, 1985, but only with respect to changes of ownership occurring on or after such date.

42 USC 1396a
note.

(2) The amendments made by this section shall not apply with respect to a change of ownership pursuant to an enforceable agreement entered into prior to October 1, 1985.

Prohibition.

State and local
governments.
42 USC 1396.

(3) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet the requirements imposed by the amendments made by this section before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

42 USC 1396a
note.

(c) GAO STUDY.—The Comptroller General shall conduct a study of the effects of the amendments made by this section, and shall report the results of such study to the Congress two years after the date of the enactment of this Act.

SEC. 9510. BEGINNING DATE OF OPTIONAL COVERAGE FOR INDIVIDUALS IN MEDICAL INSTITUTIONS.

(a) COVERAGE.—Section 1902(a)(10)(A)(ii)(V) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)(V)) is amended by inserting “for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period)” after “are in a medical institution”.

42 USC 1396a
note.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to payment for services furnished on or after October 1, 1985.

SEC. 9511. OPTIONAL COVERAGE OF CHILDREN.

(a) STATE OPTION.—Section 1905(n)(2) of the Social Security Act (42 U.S.C. 1396d(h)(2)) is amended by inserting “(or such earlier date as the State may designate)” after “September 30, 1983”.

42 USC 1396d
note.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after April 1, 1986.

SEC. 9512. OVERPAYMENT RECOVERY RULES.

(a) OVERPAYMENT RECOVERY.—Section 1903(d)(2) of the Social Security Act (42 U.S.C. 1396b(d)(2)) is amended—

(1) by inserting “(A)” after “(2)”;

(2) by designating the second sentence as subparagraph (B), properly indented and aligned below subparagraph (A); and

(3) by adding at the end thereof the following new subparagraphs:

State and local
governments.

“(C) For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 60 days in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 60 days, whether or not recovery was made.

“(D) In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).”.

(b) **EFFECTIVE DATE.**—The amendments made by this section shall apply to overpayments identified for quarters beginning on or after October 1, 1985.

42 USC 1396b
note.

SEC. 9514. REGULATIONS FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED.

The Secretary of Health and Human Services shall promulgate proposed regulations revising standards for intermediate care facilities for the mentally retarded under title XIX of the Social Security Act within 60 days after the date of the enactment of this Act.

42 USC 1396d
note.

42 USC 1396.

SEC. 9515. LIFE SAFETY CODE RECOGNITION.

For purposes of section 1905(c) of the Social Security Act, an intermediate care facility for the mentally retarded (as defined in section 1905(d) of such Act) which meets the requirements of the relevant sections of the 1985 edition of the Life Safety Code of the National Fire Protection Association shall be deemed to meet the fire safety requirements for intermediate care facilities for the mentally retarded until such time as the Secretary specifies a later edition of the Life Safety Code for purposes of such section, or the Secretary determines that more stringent standards are necessary to protect the safety of residents of such facilities.

42 USC 1396d
and notes.

SEC. 9516. CORRECTION AND REDUCTION PLANS FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED.

(a) **CORRECTION AND REDUCTION PLANS.**—Title XIX of the Social Security Act is amended by adding at the end thereof the following new subsection:

“CORRECTION AND REDUCTION PLANS FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

“SEC. 1919. (a) If the Secretary finds that an intermediate care facility for the mentally retarded has substantial deficiencies which do not pose an immediate threat to the health and safety of residents, the State may elect, subject to the limitations in this section, to—

State and local
governments.
42 USC 1396r.

“(1) submit, within the number of days specified by the Secretary in regulations which apply to submission of compliance plans with respect to deficiencies of such type, a written plan of correction which details the extent of the facility's current compliance with the standards promulgated by the Secretary, including all deficiencies identified during a validation survey, and which provides for a timetable for completion of necessary steps to correct all staffing deficiencies within 6 months, and a timetable for rectifying all physical plant deficiencies within 6 months; or

“(2) submit, within a time period consisting of the number of days specified for submissions under paragraph (1) plus 35 days, a written plan for permanently reducing the number of certified beds, within a maximum of 36 months, in order to permit any noncomplying buildings (or distinct parts thereof) to be vacated and any staffing deficiencies to be corrected (hereinafter in this section referred to as a ‘reduction plan’).

“(b) As conditions of approval of any reduction plan submitted pursuant to subsection (a)(2), the State must—

“(1) provide for a hearing to be held at the affected facility at least 35 days prior to submission of the reduction plan, with

reasonable notice thereof to the staff and residents of the facility, responsible members of the residents' families, and the general public;

"(2) demonstrate that the State has successfully provided home and community services similar to the services proposed to be provided under the reduction plan for similar individuals eligible for medical assistance; and

"(3) provide assurances that the requirements of subsection (c) shall be met with respect to the reduction plan.

"(c) The reduction plan must—

"(1) identify the number and service needs of existing facility residents to be provided home or community services and the timetable for providing such services, in 6 month intervals, within the 36-month period;

"(2) describe the methods to be used to select such residents for home and community services and to develop the alternative home and community services to meet their needs effectively;

"(3) describe the necessary safeguards that will be applied to protect the health and welfare of the former residents of the facility who are to receive home or community services, including adequate standards for consumer and provider participation and assurances that applicable State licensure and applicable State and Federal certification requirements will be met in providing such home or community services;

"(4) provide that residents of the affected facility who are eligible for medical assistance while in the facility shall, at their option, be placed in another setting (or another part of the affected facility) so as to retain their eligibility for medical assistance;

"(5) specify the actions which will be taken to protect the health and safety of the residents who remain in the affected facility while the reduction plan is in effect;

"(6) provide that the ratio of qualified staff to residents at the affected facility (or the part thereof) which is subject to the reduction plan will be the higher of—

"(A) the ratio which the Secretary determines is necessary in order to assure the health and safety of the residents of such facility (or part thereof); or

"(B) the ratio which was in effect at the time that the finding of substantial deficiencies (referred to in subsection (a)) was made; and

"(7) provide for the protection of the interests of employees affected by actions under the reduction plan, including—

"(A) arrangements to preserve employee rights and benefits;

"(B) training and retraining of such employees where necessary;

"(C) redeployment of such employees to community settings under the reduction plan; and

"(D) making maximum efforts to guarantee the employment of such employees (but this requirement shall not be construed to guarantee the employment of any employee).

"(d)(1) The Secretary must provide for a period of not less than 30 days after the submission of a reduction plan by a State, during which comments on such reduction plan may be submitted to the Secretary, before the Secretary approves or disapproves such reduction plan.

“(2) If the Secretary approves more than 15 reduction plans under this section in any fiscal year, any reduction plans approved in addition to the first 15 such plans approved, must be for a facility (or part thereof) for which the costs of correcting the substantial deficiencies (referred to in subsection (a)) are \$2,000,000 or greater (as demonstrated by the State to the satisfaction of the Secretary).

“(e)(1) If the Secretary, at the conclusion of the 6-month plan of correction described in subsection (a)(1), determines that the State has substantially failed to correct the deficiencies described in subsection (a), the Secretary may terminate the facility’s provider agreement in accordance with the provisions of section 1910(c).

“(2) In the case of a reduction plan described in subsection (a)(2), if the Secretary determines, at the conclusion of the initial 6-month period or any 6-month interval thereafter, that the State has substantially failed to meet the requirements of subsection (c), the Secretary shall—

“(A) terminate the facility’s provider agreement in accordance with the provisions of section 1910(c); or

“(B) if the State has failed to meet such requirements despite good faith efforts, disallow, for purposes of Federal financial participation, an amount equal to 5 percent of the cost of care for all eligible individuals in the facility for each month for which the State fails to meet such requirements.

“(f) The provisions of this section shall apply only to plans of correction and reduction plans approved by the Secretary within 3 years after the effective date of final regulations implementing this section.”

(b) **EFFECTIVE DATE.**—(1) The amendment made by this section shall become effective on the date of the enactment of this Act. (2) The Secretary of Health and Human Services shall issue a notice of proposed rulemaking with respect to section 1919 of the Social Security Act within 60 days after the date of the enactment of this Act, and shall allow a period of 30 days for comment thereon prior to promulgating final regulations implementing such section.

(c) **REPORT.**—The Secretary of Health and Human Services shall submit a report to the Congress on the implementation and results of section 1919 of the Social Security Act. Such report shall be submitted not later than 30 months after the effective date of final regulations promulgated to implement such section.

SEC. 9517. MODIFYING APPLICATION OF MEDICAID HMO PROVISIONS FOR CERTAIN HEALTH CENTERS.

(a) **WAIVING APPLICATION OF 75 PERCENT RULE AND CERTAIN ORGANIZATIONAL REQUIREMENTS.**—Section 1903(m)(2) of the Social Security Act (42 U.S.C. 1396b(m)(2)) is amended—

(1) in subparagraph (A), by striking out “(B) and (C)” and inserting in lieu thereof “(B), (C), and (G)”;

(2) in subparagraph (F)—

(A) by striking out “(F)(i) In the case of a contract with a health maintenance organization described in clause (ii)” and inserting in lieu thereof “(F) in the case of a contract with an entity described in subparagraph (G) or with a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) which meets the requirement of subparagraph (A)(ii)”;

(B) by striking out “such organization” and inserting in lieu thereof “such entity or organization”; and

42 USC 1396i.
Penalties.

42 USC 1396r
note.
Notice.

42 USC 1396r
note.

Contract.

42 USC 300e-9.

(C) by striking out clause (ii); and

(3) by adding at the end thereof the following new subparagraph:

“(G) In the case of an entity which is receiving (and has received during the previous two years) a grant of at least \$100,000 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act or is receiving (and has received during the previous two years) at least \$100,000 (by grant, subgrant, or subcontract) under the Appalachian Regional Development Act of 1965, clauses (i) and (ii) of subparagraph (A) shall not apply.”

(b) PERMITTING 6-MONTH CONTINUATION OF BENEFITS.—Section 1902(e)(2) of such Act (42 U.S.C. 1396a(e)(2)) is amended—

(1) in subparagraph (A)—

(A) by inserting “or with an entity described in section 1903(m)(2)(G)” after “Public Health Service Act”; and

(B) by inserting “or entity” before the period; and

(2) in subparagraph (B)—

(A) by striking out “a health maintenance organization” and inserting in lieu thereof “an organization or entity”; and

(B) by inserting “or entity” after “the organization”.

(c) HEALTH INSURING ORGANIZATIONS.—(1) Section 1903(m)(2)(A) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)) is amended, in the matter before clause (i)—

(1) by inserting “(including a health insuring organization)” after “any entity”; and

(2) by inserting “(directly or through arrangements with providers of services)” after “responsible for the provision”.

(2)(A) Except as provided in subparagraph (B), the amendments made by paragraph (1) shall apply to expenditures incurred for health insuring organizations which first become operational on or after January 1, 1986.

(B) In the case of a health insuring organization—

(i) which first becomes operational on or after January 1, 1986, but

(ii) for which the Secretary of Health and Human Services has waived, under section 1915(b) of the Social Security Act and before such date, certain requirements of section 1902 of such Act,

clauses (ii) and (iv) of section 1903(m)(2)(A) of such Act shall not apply during the period for which such waiver is effective.

SEC. 9518. EXTENSION OF MMIS DEADLINE.

(a) NEW DEADLINE.—Section 1903(r)(1)(B) of the Social Security Act (42 U.S.C. 1396b(r)(1)(B)) is amended by striking out “the earlier of” and all that follows through the end of subparagraph (B) and inserting in lieu thereof “September 30, 1985.”

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to payment under section 1903(a) of the Social Security Act for calendar quarters beginning on or after October 1, 1982.

SEC. 9519. REPORT ON ADJUSTMENT IN MEDICAID PAYMENTS FOR HOSPITALS SERVING DISPROPORTIONATE NUMBERS OF LOW INCOME PATIENTS.

The Secretary of Health and Human Services shall transmit to Congress, not later than October 1, 1986, a report that—

42 USC 254b,
254c.

40 USC app. 1.

Ante, p. 215.

42 USC 1396b
note.

42 USC 1396n.

42 USC 1396b
note.

(1) describes the methodology used by States under section 1902(a)(13)(A) of the Social Security Act, in their making payments to hospitals, in taking into account the situation of hospitals that serve a disproportionate number of low income patients with special needs;

42 USC 1396a.

(2) identifies each of those hospitals that have had the amount of their payments under that title adjusted under that section; and

(3) for each of those hospitals, describes the proportion of total inpatient-days attributable to low income patients and the proportion of total inpatient-days attributable to patients entitled to medical assistance under that title.

SEC. 9520. TASK FORCE ON TECHNOLOGY-DEPENDENT CHILDREN.

(a) **APPOINTMENT OF TASK FORCE.**—The Secretary of Health and Human Services, within six months after the date of the enactment of this Act, shall establish a task force concerning alternatives to institutional care for technology-dependent children (as defined in subsection (e)).

42 USC 1396a
note.

(b) **MEMBERSHIP.**—The task force shall include representatives of Federal and State agencies with responsibilities relating to child health, health insurers, large employers (including those that self-insure for health care costs), providers of health care to technology-dependent children, and parents of technology-dependent children.

(c) **FUNCTIONS OF TASK FORCE.**—The task force shall—

(1) identify barriers that prevent the provision of appropriate care in a home or community setting to meet the special needs of technology-dependent children; and

(2) recommend changes in the provision and financing of health care in private and public health care programs (including appropriate joint public-private initiatives) so as to provide home and community-based alternatives to the institutionalization of technology-dependent children.

(d) **REPORT.**—The task force shall make a final report to the Secretary and to the Congress on its activities not later than two years after the date of the enactment of this Act.

(e) **DEFINITION.**—In this section, the term “technology-dependent child” means a child who has a chronic illness which makes the child dependent upon the continuing use of medical care technology (such as a ventilator).

SEC. 9522. EXPANSION OF SERVICES UNDER DEMONSTRATION WAIVERS.

In the case of waivers granted to (or submitted during 1986 by) the State of Oregon under section 1915(b) of the Social Security Act, the Secretary of Health and Human Services may waive the requirements of section 1903(m)(2)(A) of such Act with respect to any entity providing services under any such waiver if such entity does not provide more than 5 of the services listed in section 1903(m)(2)(A) of such Act, and does not provide inpatient hospital services.

42 USC 1396n.

42 USC 1396b.

SEC. 9523. EXTENSION OF TEXAS WAIVER PROJECT.

(a) **RENEWED APPROVAL.**—Notwithstanding any limitations contained in section 1115 of the Social Security Act but subject to subsection (b) of this section, the Secretary of Health and Human Services, upon application, shall renew approval of demonstration project number 11-P-97473/6-06 (“Modifications under the Texas System of Care for the Elderly: Alternatives to the Institutionalized

42 USC 1315.

Aged”), previously approved under that section, until January 1, 1989.

(b) **TERMS AND CONDITIONS.**—The Secretary’s renewed approval of the project under subsection (a)—

(1) shall be on the same terms and conditions as applied to the project as of December 31, 1985; and

(2) shall remain in effect until such time as the Secretary finds that the applicant no longer complies with such terms and conditions.

SEC. 9524. WISCONSIN HEALTH MAINTENANCE ORGANIZATION WAIVER.

42 USC 1396n.
42 USC 1396b.
42 USC 1396a.

The waiver granted to the State of Wisconsin pursuant to section 1915(b) of the Social Security Act relating to the requirements of section 1903(m) of such Act in conjunction with a waiver of the requirements of section 1902(a)(23) of such Act shall, upon request by the State, be reinstated, and shall be renewable for terms of 2 years, subject to the showings required generally under section 1915(b) of such Act.

SEC. 9525. NEW JERSEY DEMONSTRATION PROJECT RELATING TO TRAINING OF AFDC RECIPIENTS AS HOME HEALTH AIDES.

42 USC 632a.

The Secretary of Health and Human Services shall continue for one additional year the demonstration project conducted by the State of New Jersey pursuant to section 966 of the Omnibus Reconciliation Act of 1980. Federal matching for such demonstration project shall be 50 percent.

SEC. 9526. REFERENCE TO PROVISIONS OF LAW PROVIDING COVERAGE UNDER, OR DIRECTLY AFFECTING, THE MEDICAID PROGRAM.

Title XIX of the Social Security Act is amended by adding at the end thereof the following new section:

“**REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM**

42 USC 1396s.

“**SEC. 1920. (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.**—For provisions of law which make additional individuals eligible for medical assistance under this title, see the following:

42 USC 602.

“(1) **AFDC.**—(A) Section 402(a)(37) of this Act (relating to individuals who lose AFDC eligibility due to increased earnings).

42 USC 605.

“(B) Section 406(h) of this Act (relating to individuals who lose AFDC eligibility due to increased collection of child or spousal support).

42 USC 614.

“(C) Section 414(g) of this Act (relating to certain individuals participating in work supplementation programs).

42 USC 1382h.

“(2) **SSI.**—Section 1619 of this Act (relating to benefits for individuals who perform substantial gainful activity despite severe medical impairment).

42 USC 673.

“(3) **FOSTER CARE AND ADOPTION ASSISTANCE.**—Section 473(b) of this Act (relating to medical assistance for children in foster care and for adopted children).

8 USC 1522.

“(4) **REFUGEE ASSISTANCE.**—Section 412(e)(5) of the Immigration and Nationality Act (relating to medical assistance for certain refugees).

42 USC 1396a
note.

“(5) **MISCELLANEOUS.**—(A) Section 230 of Public Law 93-66 (relating to deeming eligible for medical assistance certain essential persons).

“(B) Section 231 of Public Law 93-66 (relating to deeming eligible for medical assistance certain persons in medical institutions). 42 USC 1396a note.

“(C) Section 232 of Public Law 93-66 (relating to deeming eligible for medical assistance certain blind and disabled medically indigent persons). 42 USC 1396a note.

“(D) Section 13(c) of Public Law 93-233 (relating to deeming eligible for medical assistance certain individuals receiving mandatory State supplementary payments). 42 USC 1396a note.

“(E) Section 503 of Public Law 94-566 (relating to deeming eligible for medical assistance certain individuals who would be eligible for supplemental security income benefits but for cost-of-living increases in social security benefits). 42 USC 1396a note.

“(F) Section 310(b)(1) of Public Law 96-272 (relating to continuing medicaid eligibility for certain recipients of Veterans’ Administration pensions). 42 USC 1396a note.

“(b) ADDITIONAL STATE PLAN REQUIREMENTS.—For other provisions of law that establish additional requirements for State plans to be approved under this title, see the following:

“(1) Section 1618 of this Act (relating to requirement for operation of certain State supplementation programs). 42 USC 1382g.

“(2) Section 212(a) of Public Law 93-66 (relating to requiring mandatory minimum State supplementation of SSI benefits program).” 42 USC 1382 note.

SEC. 9527. CHILDREN WITH SPECIAL HEALTH CARE NEEDS.

(a) Section 501(a)(4) of the Social Security Act (42 U.S.C. 701(a)(4)) is amended by striking out “children who are crippled or who are suffering from conditions leading to crippling” and inserting in lieu thereof “children who are ‘children with special health care needs’ or who are suffering from conditions leading to such status”.

(b) Section 501(a) of such Act is amended by striking out “crippled children” in the matter following paragraph (4) and inserting in lieu thereof “children with special health care needs”.

(c) Section 501(b)(1)(A) of such Act is amended by striking out “crippled children’s services” and inserting in lieu thereof “services for children with special health care needs”.

(d) Section 502(a)(2)(B) of such Act is amended—

42 USC 702.

(1) by striking out “crippled children’s programs” and inserting in lieu thereof “programs for children with special health care needs”; and

(2) by striking out “crippled children’s services” and inserting in lieu thereof “services for children with special health care needs”.

(e) Sections 504(b)(1) and 509(b) of such Act are each amended by striking out “crippled children” and inserting in lieu thereof “children with special health care needs”. 42 USC 704, 709.

SEC. 9528. ANNUAL CALCULATION OF FEDERAL MEDICAL ASSISTANCE PERCENTAGE.

(a) ANNUAL CALCULATION.—Section 1101(a)(8)(P) of the Social Security Act is amended— 42 USC 1301.

(1) by striking out “even-numbered”; and

(2) by striking out “eight quarters” and inserting in lieu thereof “four quarters”.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to the Federal percentage (and Federal medical assistance 42 USC 1301 note.

percentage) for fiscal years 1987 and thereafter. Such amendments shall apply without regard to the requirement of section 1101(a)(8)(B) of the Social Security Act relating to the promulgation of the Federal percentage prior to November 30 of the year preceding the year in which the new Federal percentage becomes applicable. The Secretary of Health and Human Services shall promulgate such new percentage for fiscal year 1987 as soon as practicable after the date of the enactment of this Act.

SEC. 9529. MEDICAID COVERAGE RELATING TO ADOPTION ASSISTANCE AND FOSTER CARE.

(a) **STATE OF RESIDENCE.**—(1) Section 1902(a) of the Social Security Act (42 U.S.C. 1396a(a)) is amended by adding at the end thereof the following:

“For purposes of this title, any child who meets the requirements of paragraph (1) or (2) of section 473(b) shall be deemed to be a dependent child as defined in section 406 and shall be deemed to be a recipient of aid to families with dependent children under part A of title IV in the State where such child resides.”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to medical assistance furnished on or after the first calendar quarter that begins more than 90 days after the date of the enactment of this Act.

(b) **ELIGIBILITY OF CERTAIN ADOPTED CHILDREN.**—(1) Section 1902(a)(10)(A)(ii) of the Social Security Act, as amended by section 9505 of this Act, is amended—

(A) by striking out “or” at the end of subclause (VI);

(B) by striking out the semicolon at the end of subclause (VII) and inserting in lieu thereof “, or”; and

(C) by adding after subclause (VII) the following new subclause:

“(VIII) who is a child described in section 1905(a)(i)—

“(aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of title IV) between the State and an adoptive parent or parents,

“(bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has special needs for medical or rehabilitative care, and

“(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State’s foster care program under part E of title IV were applied rather than the eligibility standards and methodologies of the State’s aid to families with dependent children program under part A of title IV;”.

(2) In the case of an adoption assistance agreement (other than an agreement under part E of title IV of the Social Security Act) entered into before the date of the enactment of this Act—

(A) the requirements of subdivisions (aa) and (bb) of section 1902(a)(10)(A)(ii)(VIII) of the Social Security Act shall be deemed to be met if the State agency responsible for adoption assistance agreements determines that—

42 USC 673.

42 USC 606.

42 USC 601.

42 USC 1396a
note.

42 USC 1396d.

42 USC 670.

42 USC 1396a
note.

(i) at the time of adoptive placement the child had special needs for medical or rehabilitative care that made the child difficult to place; and

(ii) there is in effect with respect to such child an adoption assistance agreement between the State and an adoptive parent or parents; and

(B) the requirement of subdivision (cc) of such section shall be deemed to be met if the child was found by the State to be eligible for medical assistance prior to such agreement being entered into.

(3) This subsection, and the amendments made by this subsection, shall apply to adoption assistance agreements entered into before, on, or after the date of the enactment of this Act.

42 USC 1396a
note.

Subtitle C—Task Force on Long-Term Health Care Policies

SEC. 9601. RECOMMENDATIONS FOR LONG-TERM HEALTH CARE POLICIES.

(a) **ESTABLISHMENT OF TASK FORCE.**—(1) The Secretary of Health and Human Services (hereinafter in this section referred to as the “Secretary”) shall establish a Task Force on Long-Term Health Care Policies (hereinafter in this section referred to as the “Task Force”). The Task Force shall be established not later than 60 days after the date of the enactment of this Act and in consultation with the National Association of Insurance Commissioners.

42 USC 1395b
note.

(b) **COMPOSITION OF TASK FORCE.**—The Task Force shall be composed of 18 members, which shall include—

(1) two members representing the National Association of Insurance Commissioners,

(2) three members representing Federal and State agencies with responsibilities relating to health or the elderly,

(3) three members representing private insurers,

(4) three members from organizations representing consumers or the elderly, and

(5) three members from organizations representing providers of long-term health care services.

The Secretary shall designate a member of the Task Force as chair.

(c) **DEVELOPMENT OF RECOMMENDATIONS.**—The Task Force shall develop recommendations for long-term health care policies, including recommendations designed—

(1) to limit marketing and agent abuse for those policies,

(2) to assure the dissemination of such information to consumers as is necessary to permit informed choice in purchasing the policies and to reduce the purchase of unnecessary or duplicative coverage,

(3) to assure that benefits provided under the policies are reasonable in relationship to premiums charged, and

(4) to promote the development and availability of long-term health care policies which meet these recommendations.

(d) **REPORT.**—Not later than 18 months after the date of the enactment of this Act, the Task Force shall report to the Secretary, to the Committee on Energy and Commerce of the House of Representatives and to the Committee on Labor and Human Resources of the Senate respecting—

- (1) the recommendations developed under subsection (c), including an explanation of the reasons for their selection, and
- (2) such recommendations for additional activities respecting long-term health care policies as the Task Force finds appropriate.

The Secretary, in cooperation with the National Association of Insurance Commissioners, shall provide for the dissemination of the report to each of the States.

(e) **TERMINATION OF TASK FORCE.**—The Task Force shall terminate 90 days after the date of submission of the report required under subsection (d).

(f) **REPORTS OF SECRETARY.**—The Secretary shall transmit to the Committee on Energy and Commerce of the House of Representatives and to the Committee on Labor and Human Resources of the Senate two reports on—

- (1) actions taken by the States to implement the recommendations developed under this section and to recommend additional action; and
- (2) recommendations for legislative and administrative action, if any, needed to respond to issues raised by the Task Force or to improve consumer protection with respect to long-term health care policies.

The first report shall be transmitted 18 months after the date the report is made under subsection (d), and the second report shall be transmitted 18 months later.

(g) **LONG-TERM HEALTH CARE POLICY DEFINED.**—In this section, the term “long-term health care policy” means an insurance policy, or similar health benefits plan, which is designed for or marketed as providing (or making payments for) health care services (such as nursing home care and home health care) or related services (which may include home and community-based services), or both, over an extended period of time.

(h) **ASSURANCE OF STATES’ JURISDICTION.**—Nothing in this section shall be construed as recommending Federal preemption of the States in overseeing the operation and regulation of insurance carriers in their respective jurisdictions.

TITLE X—PRIVATE HEALTH INSURANCE COVERAGE

SEC. 10001. EMPLOYERS REQUIRED TO PROVIDE CERTAIN EMPLOYEES AND FAMILY MEMBERS WITH CONTINUED HEALTH INSURANCE COVERAGE AT GROUP RATES (INTERNAL REVENUE CODE AMENDMENTS).

(a) **DENIAL OF DEDUCTION FOR EMPLOYER CONTRIBUTION TO PLAN.**—Subsection (i) of section 162 of the Internal Revenue Code of 1954 (relating to deduction for trade or business expenses with respect to group health plans) is amended by redesignating paragraph (2) as paragraph (3) and by inserting after paragraph (1) the following new paragraph:

“(2) **PLANS MUST PROVIDE CONTINUATION COVERAGE TO CERTAIN INDIVIDUALS.**—

“(A) **IN GENERAL.**—No deduction shall be allowed under this section for expenses paid or incurred by an employer for any group health plan maintained by such employer

(D) TERMINATION OF PROCEEDINGS BY PLAN ADMINISTRATOR.—

(i) **IN GENERAL.**—Except as provided in clause (ii), in the case of a plan termination described in paragraph (1) with respect to which the Corporation has been provided the notification described in subparagraph (A)(iii), the termination shall not take effect.

(ii) **TERMINATIONS WITH RESPECT TO WHICH FINAL DISTRIBUTION OF ASSETS HAS COMMENCED.**—Clause (i) shall not apply with respect to a termination with respect to which the final distribution of assets has commenced before the date of the enactment of this Act unless, within 90 days after the date of the enactment of this Act, the plan has been restored in accordance with procedures issued by the Corporation pursuant to subsection (c).

(E) AUTHORITY OF CORPORATION TO EXTEND 90-DAY PERIODS TO PERMIT STANDARD TERMINATION.—The Corporation may, on a case-by-case basis in accordance with subsection (c), provide for extensions of the applicable 90-day period referred to in clause (i) or (ii) of subparagraph (B) if it is demonstrated to the satisfaction of the Corporation that—

(i) the plan could not otherwise, pursuant to the preceding provisions of this paragraph, terminate in a termination treated as a standard termination under section 4041(b) of the Employee Retirement Income Security Act of 1974 (as amended by this title), and

(ii) the extension would result in a greater likelihood that benefit commitments under the plan would be paid in full,

except that any such period may not be so extended beyond one year after the date of the enactment of this Act.

(c) AUTHORITY TO PRESCRIBE TEMPORARY PROCEDURES.—The Pension Benefit Guaranty Corporation may prescribe temporary procedures for purposes of carrying out the amendments made by this title during the 180-day period beginning on the date described in subsection (a).

Ante, p. 244.

TITLE XII—INCOME SECURITY AND RELATED PROGRAMS

Subtitle A—Old-Age, Survivors, and Disability Insurance Program

SEC. 12101. DEMONSTRATION PROJECTS INVOLVING THE DISABILITY INSURANCE PROGRAM.

(a) **EXTENSION OF WAIVER AUTHORITY.**—Section 505(a)(3) of the Social Security Disability Amendments of 1980 is amended by inserting “which is initiated before June 10, 1990” after “demonstration project under paragraph (1)”.

(b) **INTERIM REPORTS.**—Section 505(a)(4) of such Amendments is amended to read as follows:

“(4) On or before June 9 in each of the years 1986, 1987, 1988, and 1989, the Secretary shall submit to the Congress an interim report

42 USC 1310
note.

42 USC 1310
note.

on the progress of the experiments and demonstration projects carried out under this subsection together with any related data and materials which the Secretary may consider appropriate.”

(c) FINAL REPORT.—Section 505(c) of such Amendments is amended by striking out “under this section no later than five years after the date of the enactment of this Act” and inserting in lieu thereof “under subsection (a) no later than June 9, 1990”.

42 USC 1310
note.

(d) INCORPORATION OF CERTAIN REPORTS INTO SECRETARY'S ANNUAL REPORT TO CONGRESS.—Section 1110(b) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

42 USC 1310.

“(3) All reports of the Secretary with respect to projects carried out under this subsection shall be incorporated into the Secretary's annual report to the Congress required by section 704.”.

42 USC 904.

SEC. 12102. DISABILITY ADVISORY COUNCIL.

42 USC 907.

(a) APPOINTMENT OF COUNCIL.—Within ninety days after the date of the enactment of this Act, the Secretary of Health and Human Services shall appoint a special Disability Advisory Council.

(b) MEMBERSHIP OF COUNCIL.—The Disability Advisory Council shall consist of a Chairman and not more than twelve other persons, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. The appointed members shall, to the extent possible, represent organizations of employers and employees in equal numbers, medical and vocational experts from the public or private sector (or from both such sectors), organizations representing disabled people, and the public. The Council shall meet as often as may be necessary for the performance of its duties under this section, but not less often than quarterly.

(c) DUTIES OF COUNCIL.—(1) The Advisory Council shall conduct studies and make recommendations with respect to the medical and vocational aspects of disability under both title II and title XVI of the Social Security Act, including studies and recommendations relating to—

42 USC 401,
1381.

(A) the effectiveness of vocational rehabilitation programs for recipients of disability insurance benefits or supplemental security income benefits;

(B) the question of using specialists for completing medical and vocational evaluations at the State agency level in the disability determination process, including the question of requiring, in cases involving impairments other than mental impairments, that the medical portion of each case review (as well as any applicable assessment of residual functional capacity) be completed by an appropriate medical specialist employed by the appropriate State agency before any determination can be made with respect to the impairment involved;

(C) alternative approaches to work evaluation in the case of applicants for benefits based on disability and recipients of such benefits undergoing reviews of their cases, including immediate referral of any such applicant or recipient to a vocational rehabilitation agency for services at the same time he or she is referred to the appropriate State agency for a disability determination;

(D) the feasibility and appropriateness of providing work evaluation stipends for applicants for and recipients of benefits based on disability in cases where extended work evaluation is

needed prior to the final determination of their eligibility for such benefits or for further rehabilitation and related services;

(E) the standards, policies, and procedures which are applied or used by the Secretary of Health and Human Services with respect to work evaluations in order to determine whether such standards, policies, and procedures will provide appropriate screening criteria for work evaluation referrals in the case of applicants for and recipients of benefits based on disability; and

(F) possible criteria for assessing the probability that an applicant for or recipient of benefits based on disability will benefit from rehabilitation services, taking into consideration not only whether the individual involved will be able after rehabilitation to engage in substantial gainful activity but also whether rehabilitation services can reasonably be expected to improve the individual's functioning so that he or she will be able to live independently or work in a sheltered environment.

(2) For purposes of this subsection, "work evaluation" includes (with respect to any individual) a determination of—

(A) such individual's skills,

(B) the work activities or types of work activity for which such individual's skills are insufficient or inadequate,

(C) the work activities or types of work activity for which such individual might potentially be trained or rehabilitated,

(D) the length of time for which such individual is capable of sustaining work (including, in the case of the mentally impaired, the ability to cope with the stress of competitive work), and

(E) any modifications which may be necessary, in work activities for which such individual might be trained or rehabilitated, in order to enable him or her to perform such activities.

(d) **PROVISION OF ASSISTANCE TO COUNCIL; COMPENSATION OF MEMBERS.**—(1) The Disability Advisory Council is authorized to engage such technical assistance, including actuarial services, as may be required to carry out its functions, and the Secretary of Health and Human Services shall, in addition, make available to the Council such secretarial, clerical, and other assistance and such actuarial and other pertinent data prepared by the Department of Health and Human Services as the Council may require to carry out such functions.

(2) Appointed members of the Council, while serving on business of the Council (inclusive of traveltime), shall receive compensation at rates fixed by the Secretary, but not exceeding \$100 per day, and, while so serving away from their homes or regular places of business, they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government employed intermittently.

(e) **REPORTS.**—The Disability Advisory Council shall submit a report (including any interim reports the Council may have issued) of its findings and recommendations to the Secretary of Health and Human Services not later than December 31, 1986; and such report and recommendations shall thereupon be transmitted to the Congress and to the Board of Trustees of the Federal Disability Insurance Trust Fund.

(f) **TERMINATION.**—After the date of the transmittal to the Congress of the report required by subsection (e), the Disability Advisory Council shall cease to exist.

(g) CONFORMING AMENDMENTS.—(1) Section 706 of the Social Security Act is amended—

42 USC 907.

(A) by inserting “except as provided in subsection (e),” immediately before “the Secretary shall appoint” in subsection (a); and

(B) by adding at the end thereof the following new subsection: “(e) No Advisory Council on Social Security shall be appointed under subsection (a) in 1985 (or in any subsequent year prior to 1989).”

(2) Section 12 of the Social Security Disability Benefits Reform Act of 1984 is repealed.

Repeal.
42 USC 907
note.

SEC. 12103. TAXATION OF SOCIAL SECURITY BENEFITS RECEIVED BY CERTAIN CITIZENS OF POSSESSIONS OF THE UNITED STATES.

(a) GENERAL RULE.—Section 932 of the Internal Revenue Code of 1954 (relating to citizens of possessions of the United States) is amended by redesignating subsection (c) as subsection (d) and by inserting after subsection (b) the following new subsection:

26 USC 932.

“(c) TAXATION OF SOCIAL SECURITY BENEFITS.—If, for purposes of an income tax imposed in the possession, any social security benefit (as defined in section 86(d)) received by an individual described in subsection (a) is treated in a manner equivalent to that provided by section 86, then—

26 USC 86.

“(1) such benefit shall be exempt from the tax imposed by section 871, and

Infra.

“(2) no amount shall be deducted and withheld from such benefit under section 1441.

26 USC 1441.

Any income tax imposed in a possession which treats social security benefits (as defined in section 86(d)) in a manner equivalent to section 86, and which first becomes effective within 15 months after the date of the enactment of this subsection, shall, for purposes of this section, be deemed to have been in effect as of January 1, 1984.”

(b) CROSS REFERENCE.—Paragraph (3) of section 871(a) of such Code is amended by adding at the end thereof (after and below subparagraph (B)) the following new sentence:

“For treatment of certain citizens of possessions of the United States, see section 932(c).”

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits received after December 31, 1983, in taxable years ending after such date.

26 USC 932
note.

SEC. 12104. APPLICATION OF DEPENDENCY TEST TO ADOPTED GREAT-GRANDCHILDREN FOR PURPOSES OF CHILD'S INSURANCE BENEFITS.

(a) TREATMENT OF GRANDCHILDREN AND GREAT-GRANDCHILDREN ALIKE.—Section 202(d)(8)(D)(ii)(III) of the Social Security Act is amended by inserting “or great-grandchild” after “grandchild”

42 USC 402.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to benefits for which application is filed after the date of the enactment of this Act.

42 USC 402
note.

SEC. 12105. ELIMINATION OF REQUIREMENT FOR PUBLICATION OF REVISIONS IN PRE-1979 BENEFIT TABLE.

42 USC 415.

Section 215(i)(4) of the Social Security Act is amended by striking out "the Secretary shall publish" and all that follows in the last sentence and inserting in lieu thereof the following: "the Secretary shall revise the table of benefits contained in subsection (a), as in effect in December 1978, in accordance with the requirements of paragraph (2)(D) of this subsection as then in effect, except that the requirement in such paragraph (2)(D) that the Secretary publish such revision of the table of benefits in the Federal Register shall not apply."

SEC. 12106. FORMULA CLARIFICATION.

42 USC 910.

Section 709(b)(1) of the Social Security Act is amended to read as follows:

42 USC 401.

"(1) the balance in such Trust Fund as of the beginning of such year, including the taxes transferred under section 201(a) on the first day of such year and reduced by the outstanding amount of any loan (including interest thereon) theretofore made to such Trust Fund under section 201(l) or 1817(j), to".

42 USC 1395i.

SEC. 12107. EXTENSION OF 15-MONTH REENTITLEMENT PERIOD TO CHILDHOOD DISABILITY BENEFICIARIES SUBSEQUENTLY ENTITLED.

42 USC 402.

(a) **IN GENERAL.**—Section 202(d)(6)(E) of the Social Security Act is amended by striking out "the third month following the month in which he ceases to be under such disability" and inserting in lieu thereof "the termination month (as defined in paragraph (1)(G)(i), subject to section 223(e))."

42 USC 423.

(b) **CONFORMING AMENDMENT.**—Section 223(e) of such Act is amended by inserting "(d)(6)(A)(ii), (d)(6)(B)," after "(d)(1)(B)(ii)."

42 USC 402 note.

(c) **EFFECTIVE DATE.**—The amendments made by this section are effective December 1, 1980, and shall apply with respect to any individual who is under a disability (as defined in section 223(d) of the Social Security Act) on or after that date.

SEC. 12108. CHARGING OF WORK DEDUCTIONS AGAINST AUXILIARY BENEFITS IN DISABILITY CASES.

42 USC 403.

(a) **IN GENERAL.**—(1) Section 203(a)(4) of the Social Security Act is amended by striking out "preceding" in the first sentence.

(2) Section 203(a)(6) of such Act is amended—

(A) by striking out "and (5)" and inserting in lieu thereof "(4, and (5)"; and

(B) by striking out ", whether or not" and all that follows down through "further reduced" and inserting in lieu thereof "shall be reduced".

42 USC 403 note.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply with respect to benefits payable for months after December 1985.

SEC. 12109. PERFECTING AMENDMENTS TO DISABILITY OFFSET PROVISION.

42 USC 424a.

(a) **IN GENERAL.**—(1) Section 224(a)(2) of the Social Security Act is amended to read as follows:

"(2) such individual is entitled for such month to—

"(A) periodic benefits on account of his or her total or partial disability (whether or not permanent) under a work-

men's compensation law or plan of the United States or a State, or

"(B) periodic benefits on account of his or her total or partial disability (whether or not permanent) under any other law or plan of the United States, a State, a political subdivision (as that term is used in section 218(b)(2)), or an instrumentality of two or more States (as that term is used in section 218(k)), other than (i) benefits payable under title 38, United States Code, (ii) benefits payable under a program of assistance which is based on need, (iii) benefits based on service all or substantially all of which was included under an agreement entered into by a State and the Secretary under section 218, and (iv) benefits under a law or plan of the United States based on service all or part of which is employment as defined in section 210,"

42 USC 418.

(2) Section 224(a)(2)(B) of such Act (as amended by paragraph (1) of this subsection) is further amended by striking out "all or part of which" in clause (iv) and inserting in lieu thereof "all or substantially all of which".

42 USC 410.

42 USC 424a.

(b) EFFECTIVE DATES.—(1) The amendment made by subsection (a)(1) shall be effective as though it had been included or reflected in the amendment made by section 2208(a)(3) of the Omnibus Budget Reconciliation Act of 1981.

42 USC 424a note.

42 USC 424a.

(2) The amendment made by subsection (a)(2) shall apply only with respect to monthly benefits payable on the basis of the wages and self-employment income of individuals who become disabled (within the meaning of section 223(d) of the Social Security Act) after the month in which this Act is enacted.

42 USC 423.

SEC. 12110. STATE COVERAGE AGREEMENTS.

(a) MAXIMUM PERIOD OF RETROACTIVE COVERAGE.—Section 218(f)(1) of the Social Security Act is amended by striking out "is agreed to by the Secretary and the State" and inserting in lieu thereof "is mailed or delivered by other means to the Secretary".

42 USC 418.

(b) POSITIONS COMPENSATED SOLELY ON FEE BASIS.—Section 218(u)(3) of such Act is amended by striking out "is agreed to by the Secretary and the State" and inserting in lieu thereof "is mailed or delivered by other means to the Secretary".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to agreements and modifications of agreements which are mailed or delivered to the Secretary of Health and Human Services (under section 218 of the Social Security Act) on or after the date of the enactment of this Act.

42 USC 418 note.

SEC. 12111. EFFECT OF EARLY DELIVERY OF BENEFIT CHECKS.

(a) FOR OASDI PURPOSES.—Section 708 of the Social Security Act is amended by adding at the end thereof the following new subsection:

42 USC 909.

"(c) For purposes of computing the 'OASDI trust fund ratio' under section 201(l), the 'OASDI fund ratio' under section 215(i), and the 'balance ratio' under section 709(b), benefit checks delivered before the end of the month for which they are issued by reason of subsection (a) of this section shall be deemed to have been delivered on the regularly designated delivery date."

42 USC 401.

42 USC 415.

42 USC 910.

(b) FOR INCOME TAX PURPOSES.—Section 86(d) of the Internal Revenue Code of 1954 (relating to taxation of social security and tier

26 USC 86.

1 railroad retirement benefits) is amended by adding at the end thereof the following new paragraph:

42 USC 909.

“(5) EFFECT OF EARLY DELIVERY OF BENEFIT CHECKS.—For purposes of subsection (a), in any case where section 708 of the Social Security Act causes social security benefit checks to be delivered before the end of the calendar month for which they are issued, the benefits involved shall be deemed to have been received in the succeeding calendar month.”.

42 USC 909 note.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to benefit checks issued for months ending after the date of the enactment of this Act.

SEC. 12112. EXEMPTION FROM SOCIAL SECURITY COVERAGE FOR RETIRED FEDERAL JUDGES ON ACTIVE DUTY.

42 USC 409.

(a) AMENDMENT TO SOCIAL SECURITY ACT.—Section 209 of the Social Security Act is amended in the third to the last paragraph thereof (added by section 101(c)(1) of the Social Security Amendments of 1983) by striking out “shall, subject to the provisions of subsection (a) of this section, include” and inserting in lieu thereof “shall not include”.

26 USC 3121.

(b) AMENDMENT TO INTERNAL REVENUE CODE.—Section 3121(i)(5) of the Internal Revenue Code of 1954 is amended by striking out “shall, subject to the provisions of subsection (a)(1) of this section, include” and inserting in lieu thereof “shall not include”.

42 USC 409 note.

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective with respect to service performed after December 31, 1983.

SEC. 12113. RECOVERY OF OVERPAYMENTS.

42 USC 404.

(a) OASDI PAYMENTS.—Section 204(a) of the Social Security Act is amended—

(1) by inserting “(1)” after “204(a)”;

(2) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B); and

(3) by adding at the end thereof the following new paragraph:

“(2) Notwithstanding any other provision of this section, when any payment of more than the correct amount is made to or on behalf of an individual who has died, and such payment—

“(A) is made by direct deposit to a financial institution;

“(B) is credited by the financial institution to a joint account of the deceased individual and another person; and

“(C) such other person was entitled to a monthly benefit on the basis of the same wages and self-employment income as the deceased individual for the month preceding the month in which the deceased individual died,

the amount of such payment in excess of the correct amount shall be treated as a payment of more than the correct amount to such other person.”.

42 USC 1383.

(b) SSI PAYMENTS.—Section 1631(b) of the Social Security Act is amended by redesignating paragraphs (2) through (4) as paragraphs (3) through (5), and by inserting after paragraph (1) the following new paragraph:

“(2) Notwithstanding any other provision of this section, when any payment of more than the correct amount is made to or on behalf of an individual who has died, and such payment—

“(A) is made by direct deposit to a financial institution;

“(B) is credited by the financial institution to a joint account of the deceased individual and another person; and

“(C) such other person is the surviving spouse of the deceased individual, and was eligible for a payment under this title (including any State supplementation payment paid by the Secretary) as an eligible spouse (or as either member of an eligible couple) for the month in which the deceased individual died,

the amount of such payment in excess of the correct amount shall be treated as a payment of more than the correct amount to such other person.”.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply only in the case of deaths of which the Secretary is first notified on or after the date of the enactment of this Act.

42 USC 404
note.

SEC. 12114. COVERAGE OF CONNECTICUT STATE POLICE.

Notwithstanding any provision of section 218 of the Social Security Act, the Secretary of Health and Human Services shall, upon the request of the Governor of Connecticut, modify the agreement under such section between the Secretary and the State of Connecticut to provide that service performed after the date of the enactment of this Act by members of the Division of the State Police within the Connecticut Department of Public Safety, who are hired on or after May 8, 1984, and who are members of the tier II plan of the Connecticut State Employees Retirement System, shall be covered under such agreement.

42 USC 418
note.

SEC. 12115. GENERAL EFFECTIVE DATE OF SUBTITLE.

Except as otherwise specifically provided, the preceding provisions of this subtitle, including the amendments made thereby, shall take effect on the first day of the month following the month in which this Act is enacted.

42 USC 415
note.

Subtitle B—Supplemental Security Income Program

SEC. 12201. AMENDMENTS RELATING TO STATE SUPPLEMENTATION UNDER SSI.

(a) **PASSTHROUGH RELATING TO OPTIONAL STATE SUPPLEMENTATION.**—Section 1618 of the Social Security Act is amended by adding at the end thereof the following new subsection:

42 USC 1382g.

“(f) The Secretary shall not find that a State has failed to meet the requirements imposed by subsection (a) with respect to the levels of its supplementary payments for the period January 1, 1984, through December 31, 1985, if in the period January 1, 1986, through December 31, 1986, its supplementary payment levels (other than to recipients of benefits determined under section 1611(e)(1)(B)) are not less than those in effect in December 1976, increased by a percentage equal to the percentage by which payments under section 1611(b) of this Act and section 211(a)(1)(A) of Public Law 93-66 have been increased as a result of all adjustments under section 1617 (a) and (c) which have occurred after December 1976 and before February 1986.”.

42 USC 1382.

42 USC 1382
note.
42 USC 1382f.

42 USC 1382e. (b) FEDERAL ADMINISTRATION OF STATE SUPPLEMENTATION.—Section 1616(b) of such Act is amended by adding at the end thereof (after and below paragraph (2)) the following new sentence:

42 USC 1382. "At the option of the State (but subject to paragraph (2) of this subsection), the agreement between the Secretary and such State entered into under subsection (a) shall be modified to provide that the Secretary will make supplementary payments, on and after an effective date to be specified in the agreement as so modified, to individuals receiving benefits determined under section 1611(e)(1)(B)."

SEC. 12202. PRESERVATION OF BENEFIT STATUS FOR DISABLED WIDOWS AND WIDOWERS WHO LOST SSI BENEFITS BECAUSE OF 1983 CHANGES IN ACTUARIAL REDUCTION FORMULA.

42 USC 1383c. (a) IN GENERAL.—Section 1634 of the Social Security Act is amended—

(1) by inserting "(a)" after "SEC. 1634.", and

(2) by adding at the end the following new subsection:

Insurance. "(b)(1) An eligible disabled widow or widower (described in paragraph (2)) who is entitled to a widow's or widower's insurance benefit based on a disability for any month under section 202 (e) or (f) but is not eligible for benefits under this title in that month, and who applies for the protection of this subsection under paragraph (3), shall be deemed for purposes of title XIX to be an individual with respect to whom benefits under this title are paid in that month if he or she—

42 USC 1396. "(A) has been continuously entitled to such widow's or widower's insurance benefits from the first month for which the increase described in paragraph (2)(C) was reflected in such benefits through the month involved, and

42 USC 415. "(B) would be eligible for benefits under this title in the month involved if the amount of the increase described in paragraph (2)(C) in his or her widow's or widower's insurance benefits, and any subsequent cost-of-living adjustments in such benefits under section 215(i), were disregarded.

42 USC 401. "(2) For purposes of paragraph (1), the term 'eligible disabled widow or widower' means an individual who—

"(A) was entitled to a monthly insurance benefit under title II for December 1983,

"(B) was entitled to a widow's or widower's insurance benefit based on a disability under section 202 (e) or (f) for January 1984 and with respect to whom a benefit under this title was paid in that month, and

42 USC 402 and note. "(C) because of the increase in the amount of his or her widow's or widower's insurance benefits which resulted from the amendments made by section 134 of the Social Security Amendments of 1983 (Public Law 98-21) (eliminating the additional reduction factor for disabled widows and widowers under age 60), was ineligible for benefits under this title in the first month in which such increase was paid to him or her (and in which a retroactive payment of such increase for prior months was not made).

"(3) This subsection shall only apply to an individual who files a written application for protection under this subsection, in such manner and form as the Secretary may prescribe, during the 15-month period beginning with the month in which this subsection is enacted.

“(4) For purposes of this subsection, the term ‘benefits under this title’ includes payments of the type described in section 1616(a) or of the type described in section 212(a) of Public Law 93-66.”

42 USC 1382e.
42 USC 1382
note.
42 USC 1383c
note.

(b) IDENTIFICATION OF BENEFICIARIES.—(1) As soon as possible after the date of the enactment of this Act, the Secretary of Health and Human Services shall provide each State with the names of all individuals receiving widow's or widower's insurance benefits under subsection (e) or (f) of section 202 of the Social Security Act based on a disability who might qualify for medical assistance under the plan of that State approved under title XIX of such Act by reason of the application of section 1634(b) of the Social Security Act.

42 USC 402.
42 USC 1396.
42 USC 1383c.

(2) Each State shall—

(A) using the information so provided and any other information it may have, promptly notify all individuals who may qualify for medical assistance under its plan by reason of such section 1634(b) of their right to make application for such assistance,

(B) solicit their applications for such assistance, and

(C) make the necessary determination of such individuals' eligibility for such assistance under such section and under such title XIX.

(c) EFFECTIVE DATE.—The amendment made by subsection (a)(2) shall not have the effect of deeming an individual eligible for medical assistance for any month which begins less than two months after the date of the enactment of this Act.

42 USC 1383c
note.

Subtitle C—AFDC, Adoption Assistance, and Foster Care Programs

SEC. 12301. AFDC QUALITY CONTROL STUDIES AND PENALTY MORATORIUM

(a) STUDIES.—(1) The Secretary of Health and Human Services (hereafter referred to in this section as the “Secretary”) shall conduct a study of quality control systems for the Aid to Families with Dependent Children Program under title IV-A of the Social Security Act and for the Medicaid Program under title XIX of such Act. The study shall examine how best to operate such systems in order to obtain information which will allow program managers to improve the quality of administration, and provide reasonable data on the basis of which Federal funding may be withheld for States with excessive levels of erroneous payments.

42 USC 603
note.

(2) The Secretary shall also contract with the National Academy of Sciences to conduct a concurrent independent study for the purpose described in paragraph (1). For purposes of such study, the Secretary shall provide to the National Academy of Sciences any relevant data available to the Secretary at the onset of the study and on an ongoing basis.

42 USC 601.
42 USC 1396.

Contract.

(3) The Secretary and the National Academy of Sciences shall report the results of their respective studies to the Congress within one year after the date of the enactment of this Act.

Report.

(b) MORATORIUM ON PENALTIES.—(1) During the 24-month period beginning with the first calendar quarter which begins after the date of the enactment of this Act (hereafter in this section referred to as the “moratorium period”), the Secretary shall not impose any reductions in payments to States pursuant to section 403(i) of the

42 USC 603.
42 USC 601.
Puerto Rico.
Guam.
Virgin Islands.
American
Samoa.
Northern
Mariana Islands.
Regulations.
42 USC 1396.

Social Security Act (or prior regulations), or pursuant to any comparable provision of law relating to the programs under title IV-A of such Act in Puerto Rico, Guam, the Virgin Islands, American Samoa, or the Northern Mariana Islands.

(2) During the moratorium period, the Secretary and the States shall continue to operate the quality control systems in effect under title IV-A of the Social Security Act, and to calculate the error rates under the provisions referred to in paragraph (1).

(c) **RESTRUCTURED QUALITY CONTROL SYSTEMS.**—(1) Not later than 18 months after the date of the enactment of this Act, the Secretary shall publish regulations which shall—

(A) restructure the quality control systems under titles IV-A and XIX of the Social Security Act to the extent the Secretary determines to be appropriate, taking into account the studies conducted under subsection (a); and

(B) establish, taking into account the studies conducted under subsection (a), criteria for adjusting the reductions which shall be made for quarters prior to the implementation of the restructured quality control systems so as to eliminate reductions for those quarters which would not be required if the restructured quality control systems had been in effect during those quarters.

(2) Beginning with the first calendar quarter after the moratorium period, the Secretary shall implement the revised quality control systems, and shall reduce payments to States—

(A) for quarters after the moratorium period in accordance with the restructured quality control systems; and

(B) for quarters in and before the moratorium period, as provided under the regulations described in paragraph (1)(B).

(d) **EFFECTIVE DATE.**—This section shall become effective on the date of the enactment of this Act.

SEC. 12303. AFDC AUTOMATION REQUIREMENTS.

(a) **IN GENERAL.**—Section 402(e)(2) of the Social Security Act is amended by adding at the end thereof the following new subparagraph:

“(C) If the Secretary determines that such a system has not been implemented by the State by the date specified for implementation in the State’s advance automatic data processing planning document, then the Secretary shall reduce payments to such State, in accordance with section 403(b), in an amount equal to 40 percent of the expenditures referred to in section 403(a)(3)(B) with respect to which payments were made to the State under section 403(a)(3)(B). The Secretary may extend the deadline for implementation if the State demonstrates to the satisfaction of the Secretary that the State cannot implement such system by the date specified in such planning document due to circumstances beyond the State’s control.”

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall become effective on the date of the enactment of this Act, but shall apply only with respect to sums expended by the States for the purposes described in section 403(a)(3)(B) of the Social Security Act on or after the date of the enactment of this Act.

SEC. 12304. THIRD-PARTY LIABILITY.

(a) **IN GENERAL.**—Section 402(a)(26) of the Social Security Act is amended—

State and local
governments.

42 USC 602.

State and local
governments.

42 USC 603.

State and local
governments.
42 USC 602 note.

42 USC 602.

(1) by striking out the comma at the end of subparagraph (A) and inserting in lieu thereof a semicolon;

(2) by adding "and" after the semicolon at the end of subparagraph (B); and

(3) by adding after subparagraph (B) the following new subparagraph:

"(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the State's plan for medical assistance under title XIX, unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary, which standards shall take into consideration the best interests of the individuals involved; but the State shall not be subject to any financial penalty in the administration or enforcement of this subparagraph as a result of any monitoring, quality control, or auditing requirements;"

State and local governments.

42 USC 1396.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to calendar quarters beginning on or after the date of the enactment of this Act.

42 USC 602 note.

SEC. 12305. PROVISIONS RELATING TO MEDICAID COVERAGE UNDER THE ADOPTION ASSISTANCE AND FOSTER CARE PROGRAMS.

(a) **IN GENERAL.**—Section 473(b) of the Social Security Act is amended to read as follows:

42 USC 673.

"(b) For purposes of titles XIX and XX, any child—

42 USC 1396, 1397.

"(1)(A) who is a child described in subsection (a)(1), and

"(B) with respect to whom an adoption assistance agreement is in effect under this section (whether or not adoption assistance payments are provided under the agreement or are being made under this section), including any such child who has been placed for adoption in accordance with applicable State and local law (whether or not an interlocutory or other judicial decree of adoption has been issued), or

"(2) with respect to whom foster care maintenance payments are being made under section 472,

42 USC 672.

shall be deemed to be a dependent child as defined in section 406 and shall be deemed to be a recipient of aid to families with dependent children under part A of this title in the State where such child resides."

42 USC 606.

(b) **CONFORMING AMENDMENTS.**—(1) Section 473(c)(2) of such Act is amended—

(A) by striking out "without providing adoption assistance" in clause (A) and inserting in lieu thereof "without providing adoption assistance under this section or medical assistance under title XIX"; and

(B) by inserting "or medical assistance under title XIX" before the period at the end thereof.

(2) Section 475(3) of such Act is amended by striking out "the adoption assistance payments and any additional services and assistance" in clause (A) of the first sentence and inserting in lieu thereof "any adoption assistance payments and any other services and assistance".

42 USC 675.

(3) Section 1902(a)(10)(A)(i)(I) of such Act is amended by striking out "or 406(h)" and inserting in lieu thereof ", 406(h), or 473(b)".

42 USC 1396a.

42 USC 673 note. (c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to medical assistance furnished in or after the first calendar quarter beginning more than 90 days after the date of the enactment of this Act.

SEC. 12306. EXTENSION OF VOLUNTARY PLACEMENT, AND CEILING AND TRIGGER PROVISIONS, RELATING TO FOSTER CARE.

42 USC 674. (a) Section 474(b) of the Social Security Act is amended—
 (1) in paragraphs (1), (2)(B), and (4)(B), by striking out “1985” and inserting in lieu thereof “1987”;

(2) in paragraph (2)(A)—

(A) by inserting “and” at the end of clause (ii), and

(B) by striking out clauses (iii), (iv), and (v) and inserting in lieu thereof the following:

42 USC 620. “(iii) with respect to each of the fiscal years 1983 through 1987, only if the amount appropriated under section 420 for such fiscal year is equal to \$266,000,000.”; and

(3) in paragraph (5)(A)—

(A) by striking out “October 1, 1985” and inserting in lieu thereof “October 1, 1987”, and

(B) in clause (ii), by striking out “1984 and 1985” and inserting in lieu thereof “1984 through 1987”.

(b) Paragraphs (1) and (2) of section 474(c) of such Act are each amended by striking out “1985” and inserting in lieu thereof “1987”.

42 USC 672 note. (c)(1) Section 102(a)(1) of the Adoption Assistance and Child Welfare Act of 1980 (Public Law 96-272) is amended by striking out “1985” and inserting in lieu thereof “1987”.

42 USC 672 note. (2) Section 102(c) of such Act is amended by striking out “1985” each place it appears and inserting in lieu thereof “1987”.

SEC. 12307. INDEPENDENT LIVING INITIATIVES.

(a) **INDEPENDENT LIVING INITIATIVES.**—Part E of title IV of the Social Security Act is amended by adding at the end thereof the following new section:

“**INDEPENDENT LIVING INITIATIVES**

State and local
governments.
42 USC 677.

“**SEC. 477.** (a) Payments shall be made in accordance with this section for the purpose of assisting States and localities in establishing and carrying out programs designed to assist children, with respect to whom foster care maintenance payments are being made by the State under this part and who have attained age 16, in making the transition from foster care to independent living. Any State which provides for the establishment and carrying out of one or more such programs in accordance with this section for a fiscal year shall be entitled to receive payments under this section for such fiscal year, in an amount determined under subsection (e). Such payments shall be made only for the fiscal years 1987 and 1988.

State and local
governments.
Contracts.

“(b) The State agency administering or supervising the administration of the State’s programs under this part shall be responsible for administering or supervising the administration of the State’s programs described in subsection (a). Payment under this section shall be made to the State, and shall be used for the purpose of conducting and providing in accordance with this section (directly or under contracts with local governmental entities or private non-

profit organizations) the activities and services required to carry out the program or programs involved.

“(c) In order for a State to receive payments under this section for any fiscal year, the State agency must submit to the Secretary, in such manner and form as the Secretary may prescribe, a description of the program together with satisfactory assurances that the program will be operated in an effective and efficient manner and will otherwise meet the requirements of this section. In the case of payments for fiscal year 1987, such description and assurances must be submitted within 90 days after the Secretary promulgates regulations as required under subsection (i), and in the case of payments for fiscal year 1988, such description and assurances must be submitted prior to January 1, 1988.

State and local governments.

“(d) In carrying out the purpose described in subsection (a), it shall be the objective of each program established under this section to help the individuals participating in such program to prepare to live independently upon leaving foster care. Such programs may include (subject to the availability of funds) programs to—

“(1) enable participants to seek a high school diploma or its equivalent or to take part in appropriate vocational training;

Education.

“(2) provide training in daily living skills, budgeting, locating and maintaining housing, and career planning;

“(3) provide for individual and group counseling;

“(4) integrate and coordinate services otherwise available to participants;

“(5) provide for the establishment of outreach programs designed to attract individuals who are eligible to participate in the program;

“(6) provide each participant a written transitional independent living plan which shall be based on an assessment of his needs, and which shall be incorporated into his case plan, as described in section 475(1); and

42 USC 675.

“(7) provide participants with other services and assistance designed to improve their transition to independent living.

“(e)(1) The amount to which a State shall be entitled under section 474(a)(4) for each of the fiscal years 1987 and 1988 shall be an amount which bears the same ratio to \$45,000,000 as such State's average number of children receiving foster care maintenance payments under this part in fiscal year 1984 bears to the total of the average number of children receiving such payments under this part for all States for fiscal year 1984.

State and local governments.
42 USC 674.

“(2) If any State does not apply for funds under this section for any fiscal year within the time provided in subsection (c), the funds to which such State would have been entitled for such fiscal year shall be reallocated to one or more other States on the basis of their relative need for additional payments under this section (as determined by the Secretary).

“(3) Any amounts payable to States under this section shall be in addition to amounts payable to States under subsections (a)(1), (a)(2), and (a)(3) of section 474, and shall supplement and not replace any other funds which may be available for the same general purposes in the localities involved.

“(f) Payments made to a State under this section for any fiscal year—

“(1) shall be used only for the specific purposes described in this section;

"(2) may be made on an estimated basis in advance of the determination of the exact amount, with appropriate subsequent adjustments to take account of any error in the estimates; and

"(3) shall be expended by such State in such fiscal year or in the succeeding fiscal year.

Report.

"(g)(1) Not later than March 1, 1988, each State shall submit to the Secretary a report on the programs carried out with the amounts received under this section. Such report—

"(A) shall be in such form and contain such information as may be necessary to provide an accurate description of such activities, to provide a complete record of the purposes for which the funds were spent, and to indicate the extent to which the expenditure of such funds succeeded in accomplishing the purpose described in subsection (a); and

"(B) shall specifically contain such information as the Secretary may require in order to carry out the evaluation under paragraph (2).

"(2) Not later than July 1, 1988, the Secretary, on the basis of the reports submitted by States under paragraph (1) for the fiscal year 1987, and on the basis of such additional information as the Secretary may obtain or develop, shall evaluate the use by States of the payments made available under this section for such fiscal year with respect to the purpose of this section, with the objective of appraising the achievements of the programs for which such payments were made available, and developing comprehensive information and data on the basis of which decisions can be made with respect to the improvement of such programs and the necessity for providing further payments in subsequent years. The Secretary shall report such evaluation to the Congress. As a part of such evaluation, the Secretary shall include, at a minimum, a detailed overall description of the number and characteristics of the individuals served by the programs, the various kinds of activities conducted and services provided and the results achieved, and shall set forth in detail findings and comments with respect to the various State programs and a statement of plans and recommendations for the future.

"(h) Notwithstanding any other provision of this title, payments made and services provided to participants in a program under this section, as a direct consequence of their participation in such program, shall not be considered as income or resources for purposes of determining eligibility (or the eligibility of any other persons) for aid under the State's plan approved under section 402 or 471, or for purposes of determining the level of such aid.

42 USC 602, 671.

Regulations.

"(i) The Secretary shall promulgate final regulations for implementing this section within 60 days after the date of the enactment of this section."

42 USC 675.

(b) **CASE PLANS.**—Section 475(1) of such Act is amended by adding at the end thereof the following: "Where appropriate, for a child age 16 or over, the case plan must also include a written description of the programs and services which will help such child prepare for the transition from foster care to independent living."

42 USC 674.

(c) **PAYMENTS TO STATES.**—Section 474(a) of such Act is amended—

(1) by striking out the period at the end of paragraph (3) and inserting in lieu thereof "; plus"; and

(2) by adding at the end thereof the following new paragraph:

"(4) an amount for transitional independent living programs as provided in section 477."

Ante, p. 294.

(d) CONFORMING AMENDMENT.—Section 470 of such Act is amended by striking out “foster care and adoption assistance” and inserting in lieu thereof “foster care, adoption assistance, and transitional independent living programs”. 42 USC 670.

Subtitle D—Provisions Relating to Unemployment Compensation

SEC. 12401. RECOVERY OF UNEMPLOYMENT BENEFIT OVERPAYMENTS.

(a) IN GENERAL.—(1) Section 303(a)(5) of the Social Security Act is amended by inserting before “; and” at the end thereof the following: “: *Provided further*, That amounts may be deducted from unemployment benefits and used to repay overpayments as provided in subsection (g)”. 42 USC 503.

(2) Section 303 of such Act is amended by adding at the end thereof the following new subsection:

“(g)(1) A State may deduct from unemployment benefits otherwise payable to an individual an amount equal to any overpayment made to such individual under an unemployment benefit program of the United States or of any other State, and not previously recovered. The amount so deducted shall be paid to the jurisdiction under whose program such overpayment was made. Any such deduction shall be made only in accordance with the same procedures relating to notice and opportunity for a hearing as apply to the recovery of overpayments of regular unemployment compensation paid by such State. State and local governments.”

“(2) Any State may enter into an agreement with the Secretary of Labor under which—

“(A) the State agrees to recover from unemployment benefits otherwise payable to an individual by such State any overpayments made under an unemployment benefit program of the United States to such individual and not previously recovered, in accordance with paragraph (1), and to pay such amounts recovered to the United States for credit to the appropriate account, and

“(B) the United States agrees to allow the State to recover from unemployment benefits otherwise payable to an individual under an unemployment benefit program of the United States any overpayments made by such State to such individual under a State unemployment benefit program and not previously recovered, in accordance with the same procedures as apply under paragraph (1).

“(3) For purposes of this subsection, ‘unemployment benefits’ means unemployment compensation, trade adjustment allowances, and other unemployment assistance.”

(b) CONFORMING AMENDMENTS.—(1) Section 3304(a)(4) of the Internal Revenue Code of 1954 is amended— 26 USC 3304.

(A) by striking out “and” at the end of subparagraph (B);
(B) by adding “and” at the end of subparagraph (C); and
(C) by adding at the end thereof the following new subparagraph:

“(D) amounts may be deducted from unemployment benefits and used to repay overpayments as provided in section 303(g) of the Social Security Act;”.

(2) Section 3306(f) of such Code is amended—

26 USC 3306.

- (A) by striking out “and” at the end of paragraph (1);
- (B) by striking out the period at the end of paragraph (2) and inserting in lieu thereof “, and”; and
- (C) by adding at the end thereof the following new paragraph:
 “(3) amounts may be deducted from unemployment benefits and used to repay overpayments as provided in section 303(g) of the Social Security Act.”.

42 USC 503.

42 USC 503 note.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to recoveries made on or after the date of the enactment of this Act and shall apply with respect to overpayments made before, on, or after such date.

SEC. 12402. SUPPLEMENTAL UNEMPLOYMENT COMPENSATION FOR CERTAIN INDIVIDUALS.

(a) **IN GENERAL.**—If—

(1) an individual was receiving Federal supplemental compensation for the week which includes March 31, 1985, or a series of consecutive weeks which began with such week, and

(2) such individual did not meet the consecutive-week eligibility requirements of the Federal Supplemental Compensation Act of 1982 during any period of 1 or more subsequent weeks by reason of performing temporary disaster services described in subsection (e),

weeks in such period shall be disregarded for purposes of the consecutive-week requirement of section 602(f)(2)(B) of such Act, and, notwithstanding the requirements of State law relating to the availability for work, the active search for work, or the refusal to accept work, such individual shall be entitled to payment of Federal supplemental compensation for each week of unemployment which is described in subsection (b) and for which a certification of unemployment is made by such individual in accordance with subsection (c).

(b) **WEEKS FOR WHICH PAYMENT SHALL BE MADE.**—A week of unemployment for which payment shall be made under subsection (a) is a week which occurred during the period which commences with the first week beginning after the close of the period described in subsection (a)(2) and ends with the beginning of the first week in which the individual was employed after the close of such period.

(c) **CERTIFICATION.**—The certification of unemployment referred to in subsection (a) shall be a certification—

(1) that is made on a form provided by the State agency concerned and signed by the individual; and

(2) that identifies the weeks of unemployment for which the individual is making the certification.

(d) **LIMITATION ON AMOUNT OF PAYMENT.**—In no case may the total amount paid to an individual under subsection (a) exceed the amount remaining in the account established for such individual under section 602(e) of the Federal Supplemental Compensation Act of 1982 after payments were made from such account for weeks of unemployment beginning before the period described in subsection (a)(2).

(e) **DEFINITION.**—For purposes of subsection (a), the term “temporary disaster services” means services performed as a member of the National Guard after being called up by the Governor of a State to perform services related to a major disaster that was declared on June 3, 1985, by the President of the United States under the Disaster Relief Act of 1974.

26 USC 3304
note.26 USC 3304
note.26 USC 3304
note.State and local
governments.

Armed Forces.

42 USC 5121
note.

(c) **EXISTING REDUCTION IN RATES FOR PERIOD AFTER TEMPORARY INCREASE RETAINED.**—So much of subsection (e) of section 4121 (relating to temporary increase in amount of tax) as precedes paragraph (2) is amended to read as follows: 26 USC 4121.

“(e) **REDUCTION IN AMOUNT OF TAX.**—

“(1) **IN GENERAL.**—Effective with respect to sales after the temporary increase termination date, subsection (b) shall be applied—

“(A) by substituting ‘\$.50’ for ‘\$1.10’,

“(B) by substituting ‘\$.25’ for ‘\$.55’, and

“(C) by substituting ‘2 percent’ for ‘4.4 percent’.”

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to sales after March 31, 1986. 26 USC 4121 note.

SEC. 13204. ONLY RAILROAD RETIREMENT BENEFITS EQUIVALENT TO SOCIAL SECURITY BENEFITS TREATED AS TIER 1 BENEFITS.

(a) **IN GENERAL.**—Paragraph (4) of section 86(d) (defining Social Security benefits) is amended to read as follows: 26 USC 86.

“(4) **TIER 1 RAILROAD RETIREMENT BENEFIT.**—For purposes of paragraph (1), the term ‘tier 1 railroad retirement benefit’ means—

“(A) the amount of the annuity under the Railroad Retirement Act of 1974 equal to the amount of the benefit to which the taxpayer would have been entitled under the 45 USC 231.

Social Security Act if all of the service after December 31, 1936, of the employee (on whose employment record the annuity is being paid) had been included in the term ‘employment’ as defined in the Social Security Act, and 42 USC 1305 et seq.

“(B) a monthly annuity amount under section 3(f)(3) of the Railroad Retirement Act of 1974.” 45 USC 231b.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to any monthly benefit for which the generally applicable payment date is after December 31, 1985. 26 USC 86 note.

SEC. 13205. MEDICARE COVERAGE OF, AND APPLICATION OF HOSPITAL INSURANCE TAX TO, NEWLY HIRED STATE AND LOCAL GOVERNMENT EMPLOYEES.

(a) **APPLICATION OF HOSPITAL INSURANCE TAX TO NEWLY HIRED EMPLOYEES OF STATE AND LOCAL GOVERNMENTS.**—

(1) **IN GENERAL.**—Subsection (u) of section 3121 (relating to application of hospital insurance tax to Federal employment) is amended to read as follows: 26 USC 3121.

“(u) **APPLICATION OF HOSPITAL INSURANCE TAX TO FEDERAL, STATE, AND LOCAL EMPLOYMENT.**—

“(1) **FEDERAL EMPLOYMENT.**—For purposes of the taxes imposed by sections 3101(b) and 3111(b), subsection (b) shall be applied without regard to paragraph (5) thereof. 26 USC 3101, 3111.

“(2) **STATE AND LOCAL EMPLOYMENT.**—For purposes of the taxes imposed by sections 3101(b) and 3111(b)—

“(A) **IN GENERAL.**—Except as provided in subparagraphs (B) and (C), subsection (b) shall be applied without regard to paragraph (7) thereof.

“(B) **EXCEPTION FOR CERTAIN SERVICES.**—Service shall not be treated as employment by reason of subparagraph (A) if—

“(i) the service is included under an agreement under section 218 of the Social Security Act, or 42 USC 418.

District of
Columbia.

“(ii) the service is performed—

“(I) by an individual who is employed by a State or political subdivision thereof to relieve him from unemployment,

“(II) in a hospital, home, or other institution by a patient or inmate thereof as an employee of a State or political subdivision thereof or of the District of Columbia,

“(III) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency, or

“(IV) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training.

As used in this subparagraph, the terms ‘State’ and ‘political subdivision’ have the meanings given those terms in section 218(b) of the Social Security Act.

42 USC 418.

“(C) EXCEPTION FOR CURRENT EMPLOYMENT WHICH CONTINUES.—Service performed for an employer shall not be treated as employment by reason of subparagraph (A) if—

“(i) such service would be excluded from the term ‘employment’ for purposes of this chapter if subparagraph (A) did not apply;

“(ii) such service is performed by an individual—

“(I) who was performing substantial and regular service for remuneration for that employer before April 1, 1986,

“(II) who is a bona fide employee of that employer on March 31, 1986, and

“(III) whose employment relationship with that employer was not entered into for purposes of meeting the requirements of this subparagraph; and

“(iii) the employment relationship with that employer has not been terminated after March 31, 1986.

“(D) TREATMENT OF AGENCIES AND INSTRUMENTALITIES.—For purposes of subparagraph (C), under regulations—

District of
Columbia.

42 USC 418.

“(i) All agencies and instrumentalities of a State (as defined in section 218(b) of the Social Security Act) or of the District of Columbia shall be treated as a single employer.

“(ii) All agencies and instrumentalities of a political subdivision of a State (as so defined) shall be treated as a single employer and shall not be treated as described in clause (i).

“(3) MEDICARE QUALIFIED GOVERNMENT EMPLOYMENT.—For purposes of this chapter, the term ‘medicare qualified government employment’ means service which—

“(A) is employment (as defined in subsection (b)) with the application of paragraphs (1) and (2), but

“(B) would not be employment (as so defined) without the application of such paragraphs.”

(2) CONFORMING AMENDMENTS.—

(A)(i) Section 3125 (relating to returns in the case of governmental employees in Guam, American Samoa, and the District of Columbia) is amended by redesignated subsections (a), (b), and (c) as subsections (b), (c), and (d), respectively, and by inserting before subsection (b) (as so redesignated) the following new subsection:

26 USC 3125.
Guam.
American
Samoa.
District of
Columbia.

“(a) STATES.—Except as otherwise provided in this section, in the case of the taxes imposed by sections 3101(b) and 3111(b) with respect to service performed in the employ of a State or any political subdivision thereof (or any instrumentality of any one or more of the foregoing which is wholly owned thereby), the return and payment of such taxes may be made by the head of the agency or instrumentality having the control of such service, or by such agents as such head may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to the service of such individuals without regard to the contribution and benefit base limitation in section 3121(a)(1).”

26 USC 3101,
3111.

(ii) The section heading for such section 3125 is amended by inserting “STATES,” before “GUAM”.

(iii) The item relating to section 3125 in the table of sections for subchapter C of chapter 21 is amended by inserting “States,” before “Guam”.

(B) Subsection (b) of section 1402 is amended by striking out “medicare qualified Federal employment (as defined in section 3121(u)(2))” and inserting in lieu thereof “medicare qualified government employment (as defined in section 3121(u)(3))”.

26 USC 1402.

26 USC 3121.

(C) Section 3122 (relating to Federal service) is amended by striking out “including service which is medicare qualified Federal employment (as defined in section 3121(u)(2))” and inserting in lieu thereof “including such service which is medicare qualified government employment (as defined in section 3121(u)(3))”.

26 USC 3122.

(D) Subsection (a) of section 6205 (relating to special rules applicable to certain employment taxes) is amended by adding at the end thereof the following new paragraph:

26 USC 6205.

“(5) STATES AND POLITICAL SUBDIVISIONS AS EMPLOYER.—For purposes of this subsection, in the case of remuneration received from a State or any political subdivision thereof (or any instrumentality of any one or more of the foregoing which is wholly owned thereby) during any calendar year, each head of an agency or instrumentality, and each agent designated by either, who makes a return pursuant to section 3125 shall be deemed a separate employer.”

26 USC 3125.

(E)(i) Section 6413(a) (relating to adjustment of certain employment taxes) is amended by adding at the end thereof the following new paragraph:

26 USC 6413.

“(5) STATES AND POLITICAL SUBDIVISIONS AS EMPLOYER.—For purposes of this subsection, in the case of remuneration received from a State or any political subdivision thereof (or any instrumentality of any one or more of the foregoing which is wholly owned thereby) during any calendar year, each head of an agency or instrumentality, and each agent designated by

26 USC 3125.

either, who makes a return pursuant to section 3125 shall be deemed a separate employer."

26 USC 6413.

(ii) Section 6413(c)(2) (relating to special refunds of certain employment taxes) is amended—

(I) by striking out "3125(a)", "3125(b)", and "3125(c)" in subparagraphs (D), (E), and (F), respectively, and inserting in lieu thereof "3125(b)", "3125(c)", and "3125(d)", respectively, and

(II) by adding at the end thereof the following new subparagraph:

"(G) EMPLOYEES OF STATES AND POLITICAL SUBDIVISIONS.—

In the case of remuneration received from a State or any political subdivision thereof (or any instrumentality of any one or more of the foregoing which is wholly owned thereby) during any calendar year, each head of an agency or instrumentality, and each agent designated by either, who makes a return pursuant to section 3125(a) shall, for purposes of this subsection, be deemed a separate employer."

(b) ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS.—

(1) REVISION OF DEFINITION OF MEDICARE QUALIFIED GOVERNMENT EMPLOYMENT.—Section 210(p) of the Social Security Act (42 U.S.C. 410(p)) is amended to read as follows:

"MEDICARE QUALIFIED GOVERNMENT EMPLOYMENT

"(p)(1) For purposes of sections 226 and 226A, the term 'medicare qualified government employment' means any service which would constitute 'employment' as defined in subsection (a) of this section but for the application of the provisions of—

"(A) subsection (a)(5), or

"(B) subsection (a)(7), except as provided in paragraphs (2) and (3).

"(2) Service shall not be treated as employment by reason of paragraph (1)(B) if the service is performed—

"(A) by an individual who is employed by a State or political subdivision thereof to relieve him from unemployment,

"(B) in a hospital, home, or other institution by a patient or inmate thereof as an employee of a State or political subdivision thereof or of the District of Columbia,

"(C) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency, or

"(D) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training.

As used in this paragraph, the terms 'State' and 'political subdivision' have the meanings given those terms in section 218(b).

"(3) Service performed for an employer shall not be treated as employment by reason of paragraph (1)(B) if—

"(A) such service would be excluded from the term 'employment' for purposes of this section if paragraph (1)(B) did not apply;

"(B) such service is performed by an individual—

State and local
government.
42 USC 426,
426-1.

42 USC 418.

“(i) who was performing substantial and regular service for remuneration for that employer before April 1, 1986,

“(ii) who is a bona fide employee of that employer on March 31, 1986, and

“(iii) whose employment relationship with that employer was not entered into for purposes of meeting the requirements of this subparagraph; and

“(C) the employment relationship with that employer has not been terminated after March 31, 1986.

“(4) For purposes of paragraph (3), under regulations (consistent with regulations established under section 3121(u)(2)(D) of the Internal Revenue Code of 1954)—

26 USC 3121.

“(A) all agencies and instrumentalities of a State (as defined in section 218(b)) or of the District of Columbia shall be treated as a single employer, and

42 USC 418.

“(B) all agencies and instrumentalities of a political subdivision of a State (as so defined) shall be treated as a single employer and shall not be treated as described in subparagraph

“(A).”

(2) ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS.—

(A) FOR INDIVIDUALS AGE 65 OR OLDER AND FOR DISABLED INDIVIDUALS.—Section 226 of such Act (42 U.S.C. 426) is amended by striking out “medicare qualified Federal employment” in subsections (a)(2)(C)(i) and (b)(2)(C)(ii)(I) and inserting in lieu thereof “medicare qualified government employment”.

(B) FOR INDIVIDUALS WITH END-STAGE RENAL DISEASE.—Section 226A(a) of such Act (42 U.S.C. 426-1(a)) is amended by striking out “medicare qualified Federal employment” in paragraphs (1)(A)(ii) and (1)(B)(iii) and inserting in lieu thereof “medicare qualified government employment”.

(C) CONFORMING AMENDMENTS.—

(i) Section 1811 of such Act (42 U.S.C. 1395c) is amended by striking out “Federal employment” in clauses (1) and (2) and inserting in lieu thereof “government employment”.

(ii) Section 226(g) of such Act (42 U.S.C. 426(g)) is amended by striking out “medicare qualified Federal employment” and inserting in lieu thereof “medicare qualified government employment by virtue of service described in section 210(a)(5)”.

42 USC 410.

(c) OPTIONAL MEDICARE COVERAGE OF CURRENT EMPLOYEES.—Section 218 of the Social Security Act (42 U.S.C. 418) is amended by adding at the end the following new subsection:

“(v)(1) The Secretary shall, at the request of any State, enter into or modify an agreement with such State under this section for the purpose of extending the provisions of title XVIII, and sections 226 and 226A, to services performed by employees of such State or any political subdivision thereof who are described in paragraph (2).

State and local government.

42 USC 1395c, 426.

42 USC 426-1.

“(2) This subsection shall apply only with respect to employees—

“(A) whose services are not treated as employment as that term applies under section 210(p) by reason of paragraph (3) of such section; and

Ante, p. 316.

“(B) who are not otherwise covered under the State’s agreement under this section.

“(3) Payments by the State required under subsection (e) with respect to employees covered under this subsection shall be limited

to amounts equivalent to the sum of the taxes which would be imposed by sections 3101(b) and 3111(b) of the Internal Revenue Code of 1954 if such services for which wages were paid to such employees constituted 'employment' as defined in section 3121 of such Code.

"(4) For purposes of sections 226 and 226A of this Act, services covered under an agreement pursuant to this subsection shall be treated as 'medicare qualified government employment'.

"(5) Except as otherwise provided in this subsection, the provisions of this section shall apply with respect to services covered under the agreement pursuant to this subsection.

"(w) Notwithstanding sections 3125(a), 6205(a)(5), 6413(a)(5), and 6413(c)(2)(G) of the Internal Revenue Code of 1954, any State shall make payments of the taxes imposed with respect to services of employees of such State and of a political subdivision thereof under sections 3101(b) and 3111(b) of such Code, and reports of such services, under the same procedures as apply to payments and reports under subsection (e) of this section, but only if any employees of such State or of such political subdivision thereof respectively are covered under an agreement pursuant to this section."

(d) EFFECTIVE DATES.—

(1) HOSPITAL INSURANCE TAXES.—The amendments made by subsection (a) shall apply to services performed after March 31, 1986.

(2) MEDICARE COVERAGE.—

(A) IN GENERAL.—The amendments made by subsection (b) shall be effective after March 31, 1986, and the amendments made by paragraph (3) of that subsection shall apply to services performed (for medicare qualified government employment) after that date.

(B) TREATMENT OF CERTAIN DISABILITIES.—For purposes of establishing entitlement to hospital insurance benefits under part A of title XVIII of the Social Security Act pursuant to the amendments made by subsection (b), no individual may be considered to be under a disability for any period beginning before April 1, 1986.

(3) OPTIONAL COVERAGE OF CURRENT EMPLOYEES.—The amendment made by subsection (c) shall apply to services performed after March 31, 1986.

SEC. 13206. FULL-TIME STUDENTS NOT ELIGIBLE FOR INCOME AVERAGING.

(a) IN GENERAL.—Subsection (d) of section 1303 (defining eligible individuals for income averaging) is amended to read as follows:

"(d) ELIGIBLE INDIVIDUALS NOT TO INCLUDE FULL-TIME STUDENTS.—

"(1) IN GENERAL.—For purposes of this part, an individual shall not be an eligible individual for the computation year if, at any time during any base period year, such individual was a student.

"(2) EXCEPTION FOR MARRIED STUDENTS PROVIDING 25 PERCENT OR LESS OF JOINT INCOME.—Paragraph (1) shall not apply to any individual for any computation year if—

"(A) the individual makes a joint return for the computation year, and

"(B) not more than 25 percent of the aggregate adjusted gross income of such individual and the spouse of such

sional Budget Office for scorekeeping purposes; (D) such provision will be likely to produce a significant reduction in outlays or increase in revenues but, due to insufficient data, such reduction or increase cannot be reliably estimated.

Approved April 7, 1986.

LEGISLATIVE HISTORY—H.R. 3128 (H.R. 3500) (S. 1730):

HOUSE REPORTS: No. 99-241, Pt. 1 (Comm. on Ways and Means), Pt. 2 (Comm. on Education and Labor), Pt. 3 (Comm. on the Judiciary), No. 99-300 accompanying H.R. 3500 (Comm. on the Budget), and No. 99-453 (Comm. of Conference).

SENATE REPORT No. 99-146 accompanying S. 1730 (Comm. on the Budget).

CONGRESSIONAL RECORD:

- Vol. 131 (1985): Oct. 15, 16, 22-24; Nov. 12-14, S. 1730 considered in Senate.
Oct. 31, H.R. 3128 considered and passed House.
Nov. 14, considered and passed Senate, amended, in lieu of S. 1730.
Dec. 5, House agreed to Senate amendment with amendment.
Dec. 19, Senate agreed to conference report; House receded from its amendment and concurred in Senate amendment with amendment; Senate concurred in House amendment with amendment.
- Vol. 132 (1986): Mar. 6, House concurred in Senate amendment with amendment.
Mar. 14, Senate concurred in House amendment with amendment.
Mar. 18, House disagreed to Senate amendment. Senate insisted on its amendment.
Mar. 20, House concurred in Senate amendment.

DEFICIT REDUCTION AMENDMENTS OF 1985

JULY 31, 1985.—Ordered to be printed

Mr. ROSTENKOWSKI, from the Committee on Ways and Means,
submitted the following

R E P O R T

together with

DISSENTING AND ADDITIONAL DISSENTING VIEWS

[To accompany H.R. 3128]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means to whom was referred the bill (H.R. 3128) to make changes in spending and revenue provisions for purposes of deficit reduction and program improvement, consistent with the budget process, having considered the same, reports favorably thereon without amendment and recommends that the bill do pass.

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I. SUMMARY

A. TITLE I—MEDICARE PROVISIONS

(1) *Hospital Rate of Increase*.—The Secretary of HHS would be required to provide a 1% rate of increase to the diagnosis-related group (DRG) payments for fiscal year 1986. A 1% rate of increase

would be provided to prospective payment system (PPS)-exempt hospitals for fiscal year 1986.

(2) *Disproportionate Share Adjustment.*—The Secretary of HHS would be required to make additional payments to urban PPS hospitals with 100 beds or more serving a disproportionate share of low-income patients. The proxy measure for low-income would be the percentage of a hospital's total patient days attributable to medicaid patients (including medicaid-eligible elderly, i.e., medicare/medicaid crossovers).

The Federal DRG payment would be increased by 7% for each 10 percentage point increase in the proportion of low-income days to total days, above the minimum threshold of 15%. The maximum adjustment would be no greater than 16%. Approximately 850 hospitals would receive some adjustment under this proposal. A limited exceptions process would be established for urban hospitals with 100 beds or more. The Secretary would be required to make disproportionate share payments of 16% per DRG where a hospital can demonstrate that 30% of its inpatient care revenue is provided by local or state governments for patient care for low-income patients not covered by medicaid. The provision would expire in two years. The provision would be effective for discharges on or after October 1, 1985.

(3) *Indirect Teaching Adjustment.*—The indirect teaching adjustment would be reduced to 8.1% for fiscal years 1986 and 1987 on a variable or curvilinear basis. (CBO has estimated that the medicare per resident costs increase at a slower rate as teaching hospitals get larger.) When the disproportionate share provisions expire at the end of fiscal year 1987, the indirect teaching adjustment would rise to 8.7%. The Secretary would be prohibited from changing the manner in which residents' services to inpatients and outpatients are counted for the purposes of determining the indirect teaching adjustment. The provision would be effective for discharges on or after October 1, 1985.

(4) *Hospital Transition to National Payment Rates.*—The 50% hospital specific payment (HSP)/50% Federal DRG rate would be maintained for another year. The transition schedule in current law would continue after fiscal year 1986. The schedule therefore would be: FY 1986: 50% HSP/50% Federal DRG; FY 1987: 25% HSP/75% Federal DRG; FY 1988: 100% Federal DRG.

(5) *Direct Medical Education.*—The Secretary would be prohibited from imposing a one-year freeze on medicare payments for the direct costs of medical education.

(6) *Change the Calculation of the Medicare Part B Premium.*—The temporary provision of law under which enrollee premiums are to produce premium income equal to 25% of program costs for elderly enrollees would be extended for one additional year (1988).

(7) *Physician Fee Freeze Extension.*—On October 1, 1985, any physician who signs a participation agreement effective for the year beginning October 1, 1985, would receive an increase in medicare payments. For any physician who does not sign a participation agreement, the current 15-month freeze on medicare payments would be extended for 12 months, beginning October 1, 1985. The current prohibition on increases in actual charges of all nonparticipating physicians would also be extended for 12 months, beginning

October 1, 1985. Both participating and nonparticipating physicians would be given an increase in medicare payments on October 1, 1986; however, increases for nonparticipating physicians would be lagged one year behind those of participating physicians. A number of incentives for participation were agreed to.

(8) *Physician Payment Arm of PROPAC*.—The Director of the Congressional Office of Technology Assessment would appoint to the Prospective Payment Assessment Commission two additional members to provide representation for rural hospitals and for nurses. In addition, the Director would appoint six new members to comprise a physician payment unit, which would function as a subcommittee of the Commission. The chairman of the Commission would have discretion as to the allocation of other members of the Commission between the physician and hospital subcommittees.

The mission and duties of the physician subcommittee would be to make recommendations regarding medicare physician payment. Its ongoing duties would be to make recommendations regarding adjustments to reasonable charge levels for physician services, and/or structural changes in the medicare physician payment mechanism. The physician subcommittee would advise the Secretary on the development of a fee schedule based on a relative value scale (RVS), to be implemented by October 1, 1987.

(9) *Return on Equity for Proprietary Hospitals*.—Beginning October 1, 1986, return on equity would no longer be a medicare allowable cost for inpatient hospital services and would also be excluded in determining DRG payment rates. Beginning on October 1, 1985, for outpatient departments and all other providers, the rate of return would be reduced to one times the average rate of return on the hospital insurance trust fund.

(10) *Certain Transfers of Ownership*.—Where a State donates a hospital or skilled nursing facility to a nonprofit corporation, the basis for medicare capital-related costs to the new owner will be the lesser of the fair market value or the prior owner's historical cost (net of depreciation).

(11) *Hospital Area Wage Index*.—The Secretary of HHS would be required to implement the new gross wage index effective October 1, 1985. The requirement of retroactive application of the new wage index would be eliminated. The Secretary would be required to study and make a recommendation to the Congress on refining the area wage adjustment to reflect the higher wage costs incurred in core city areas relative to suburban areas of the same metropolitan area.

(12) *Extend the Working Aged Provision*.—The working aged provision would be amended by removing the upper age limit, thereby extending its applicability to people aged 70 and above.

(13) *Hospice Extension*.—The sunset provision of current law would be repealed. The daily payment rates would each be increased by \$10.00 a day.

(14) *Responsibilities of Hospitals in Emergency Cases*.—Three new requirements would be established for medicare hospitals and employees, as follows:

a. *Medical Screening*.—Requirement under which every patient who comes to a hospital emergency department for examination or treatment would be provided an appropriate medical screening.

b. *Necessary Stabilizing Treatment.*—Within their capacities, hospital emergency departments must provide appropriate treatment to stabilize patients who have emergency medical conditions or to provide treatment for patients in active labor, and provide for appropriate transfers.

c. *Prohibiting Inappropriate Transfers.*—The transfer of a patient with an unstable emergency medical condition would be prohibited unless (1) the benefits of the transfer outweigh the risks, and (2) the transfer is an appropriate transfer (that includes the transfer of appropriate documents) and is accomplished in an appropriate manner.

d. *Penalty.*—Failure to meet these requirements would subject the hospital to denial of medicare participation, civil monetary penalties, as well as civil enforcement by aggrieved patients. In addition, a responsible physician who knowingly fails to meet these requirements would be subject to criminal penalties up to one year imprisonment and, if the death of a patient directly resulted from such a failure, the physician would be subject to up to five years' imprisonment. These provisions would not preempt stricter state laws.

(15) *Preventive Services Demonstrations.*—The Secretary of HHS would be directed to establish demonstration projects in at least five states, under the auspices of schools of public health, to determine whether and under what conditions it would be cost-effective to include preventive services as a medicare benefit.

(16) *Health Maintenance Organization Technical Amendments.*—Technical amendments relating to health maintenance organizations (HMOs) and competitive medical plans (CMPs) would: a) clarify financial liability for patients hospitalized on the effective date of enrollment/disenrollment; b) make disenrollments effective with the first day of the first month following the month in which the disenrollment request was made; c) require all TEFRA HMO/CMPs to submit all marketing materials to HCFA for approval at least 45 days before issuance. The HMO/CMP could assume approval in the absence of a response from HCFA within the 45-day period; d) require the Secretary to publish the AAPCC annually, no later than September 7. Also, the Secretary would be required to extend for three more years medicare HMO demonstration waivers for three municipal health services HMO projects jointly sponsored by the Robert Wood Johnson Foundation and HHS.

(17) *Technical Corrections.*—Medicare technical corrections relating to the working aged provision and other minor technical corrections.

(18) *Evaluation of Preadmission Certification Programs.*—The Secretary would be required to evaluate the effectiveness of the PRO 100% preadmission certification programs in comparison with programs that require less than 100% preadmission certification, and to consider the extent to which part B carriers or private entities might perform prior approval activities in outpatient and ambulatory settings more efficiently and effectively than PROs. Furthermore, the Secretary would be required to evaluate the feasibility of extending the PRO prior approval activities to outpatient and ambulatory settings. The Secretary would be required to report his findings to Congress by December 1986.

(19) *Medicare's Reimbursement of Assistant Surgeons During Cataract Operations.*—The Secretary would be required to establish national guidelines to prohibit medicare reimbursement for assistant surgeons' charges in connection with routine cataract operations performed on either an inpatient or outpatient basis. The assistant surgeon would be prohibited from billing medicare or the beneficiary for services that did not receive prior approval. The Secretary would have authority to enforce this provision by invoking the penalty provisions that apply with respect to violations of the fee freeze.

(20) *Hospital-Based Physicians.*—On October 1, 1985, participating hospital-based physicians (HBPs) whose compensation-related charges were frozen as part of the general medicare fee freeze would, like other participating physicians, receive increases in their medicare payment based on their actual charges. Participating HBPs would receive increases that reflect charges that they made during the same base period used to update other participating physicians' charges (April 1984–March 1985). Nonparticipating HBPs would receive payments that reflect their charges during April 1984–March 1985, but deflated to approximate 1982 charges. This is the same period on which other nonparticipating physicians' payment is based. On October 1, 1986, participating and nonparticipating physicians.

(21) *Inherent reasonableness.*—In order to prevent arbitrary application of the "inherent reasonableness" clause (already in regulations), the Secretary would be required to promulgate regulations which specify explicitly the criteria of "inherent reasonableness." The Secretary would be directed to correct both excessive and deficient charges in accordance with these regulations.

The Secretary has used the "inherent reasonableness" clause in other areas of medicare reasonable charge reimbursement. The regulations which define "inherent reasonableness" would extend to all part B reasonable charge reimbursement.

(22) *Limit the Late Enrollment Penalty for Medicare Part A.*—The part A premium penalty would be limited to 10% no matter how late an individual enrolled, and the period during which the penalty is paid would be limited to twice the number of years the enrollment was delayed. At the end of this period, the premium would revert to the standard monthly premium in effect at that time.

(23) *End Stage Renal Disease Networks.*—The Secretary would be prohibited from dismantling ESRD networks, and from consolidating their organization and functions with those of any other entity, such as a Peer Review Organization.

(24) *Private Health Insurance Continuation.*—The business tax deduction for a group health plan would be denied any employer who fails to include in the plan a continuation option to (1) a widowed spouse and dependent children, (2) divorced or separated spouse and dependent children, or (3) medicare ineligible spouse and dependent children. A five year continuation option would be available to the above groups after which time they would be offered the right to convert to an individual policy. The coverage would be identical in scope to the coverage provided under the group plan to similarly situated individuals in the group. The in-

sured spouse would be required to pay both employer and employee share of the premium costs, although the employer could assume the employer share. Coverage would be cancelled during the five-year period if the employer stopped offering group health insurance, the insured spouse did not pay the premiums or became covered under another group policy or medicare, or the insured spouse remarried.

(25) *Allow Continued Medicare Waiver for Certain Areas.*—Certain local medicare reimbursement waiver programs now conducted as research projects would be allowed to continue under conditions similar to those provided for States—basically that medicare payments be less than they would be under the prospective payment program.

(26) *Medicare Coverage for Newly Hired State and Local Employees.*—Medicare coverage would be extended to all new State and local government employment. The hospital insurance portion of the FICA tax would be paid by the governmental entities and their employees. Effective date—employees hired on or after January 1, 1986.

(27) *Reimbursement for Rented Durable Medical Equipment.*—New medicare reimbursement limits would be imposed on rented durable medical equipment. During fiscal year 1986, medicare customary and prevailing charges for rented durable medical equipment would be allowed to increase by only one percent. Thereafter, medicare allowable charges for both rented and purchased durable medical equipment would rise no faster than the CPI. Medicare payment for rented equipment would only be made on the basis of mandatory assignment; i.e., the supplier would be required to accept medicare's allowable charge as his full charge and could collect from the beneficiary no more than the applicable deductible and coinsurance.

(28) *Osteopathic Referral Centers.*—Certain osteopathic rural hospitals could qualify for status as rural referral centers under the medicare PPS program if they have at least 3,000 discharges in a year and meet all other requirements for rural referral center status.

(29) *Occupational Therapy Services.*—Medicare coverage would be extended to occupational therapy services provided (a) in skilled nursing facilities (when part A coverage has been exhausted), (b) in clinics, rehabilitation agencies and (c) by therapists in independent practice (subject to the same annual \$500 limit on incurred expenses applicable to physical therapy services).

(30) *Prosthetic Lenses.*—Medicare reimbursement for prosthetic lenses would be limited as follows: (a) for cataract eyeglasses, one replacement each year; and (b) for cataract contact lenses, one original and two replacements per eye the first year after surgery and two replacements per eye each subsequent year. The Secretary would be required to apply an "inherent reasonableness" test in determining reimbursement amounts for lenses and to determine separately the reasonable charge for the related professional service.

(31) *New Jersey Medicare Reimbursement Waiver.*—The test of whether medicare reimbursement based on New Jersey's State reimbursement control system is no more costly to medicare than

payments under medicare's regular reimbursement system would be applied over a four rather than a three year period.

(32) *Study of Outlier and Transfer Policy on Rural Hospitals.*—The Secretary would be required to review the adequacy of payments under the prospective payment system's policies on outliers and transfers to determine their impact on rural hospitals, with emphasis on those hospitals with less than 100 beds, and to report to Congress findings with recommendations to address these problems by April 1, 1986.

(33) *Medicare Hospital Payment Information.*—The Secretary would be required to provide, on a timely basis, all hospital specific payment information to the Prospective Payment Assessment Commission, to the Congressional Budget Office, and to the Committees with legislative jurisdiction over part A of medicare. The provider specific information would remain confidential and would be used for analysis of the impact of the PPS system on a state by state basis, SMSA or other basis.

Proposed Report Language

Medicare Hearing and Appeals Process.—The Committee Report would indicate that the Committee believes that the current hearing and appeal procedures under both parts A and B of medicare need to be reviewed. The Committee wants to ensure that adequate procedural safeguards are provided to program beneficiaries, suppliers and providers. The Committee intends therefore, to hold hearings on this issue in the near future and, if it is warranted, to take legislative action.

Physical Therapists.—The Committee Report would indicate that the Committee believes that the requirement that independently practicing physical therapists who operate exclusively in beneficiaries' homes maintain fully-equipped offices is unnecessary. The Committee therefore intends that the Secretary eliminate this regulatory requirement.

The Committee Report would indicate that the Committee expects the Secretary to report to Congress, with recommendations on the appropriateness and feasibility of allowing health care providers (other than a physician or registered nurse that are allowed under current law) to perform the supervisory role for a home health agency. The report would be due April 1, 1986.

(B) TITLE II—TRADE PROVISIONS

(1) *Trade Adjustment Assistance.*—The Committee approved H.R. 1926, as amended and reported by the subcommittee on Trade on July 19, 1985, without further amendments. The amended bill reauthorizes TAA for workers and firms for 4 years until September 30, 1989. Amendments extend coverage to workers laid off from firms relocated overseas and to firms with production/sales losses in significant product lines; extend the collection period for worker benefits and liberalize prior employment requirements; remove matching share requirements for certain firm assistance; and improve program administration.

(2) *Customs, ITC and USTR Authorization.*—The Committee approved the substance of H.R. 2250 as reported by the Subcommittee

on Trade with a minor technical amendment. This authorization would restore the Administration's proposed cut of 887 positions and add an additional 800 front-line Customs personnel. It is expected that the enhanced enforcement capability resulting from the additional personnel will result in a net increase in Customs revenues of about \$1.15 billion over a 3-year period.

(3) *Customs User Fees*.—The Committee approved the user fee concept in H.R. 3034, as reported by the Subcommittee on Trade, with amendments. As amended, fees would be assessed on the arrival of commercial vessels over 100 tons (\$425), trucks (\$5), trains (\$5 per car), private yachts, boats, and general aviation (\$25 per year) and on passengers arriving on commercial aircraft, trains and vessels (\$1 for contiguous countries, U.S. territories and adjacent islands and \$5 for all other countries). The receipts from all reimbursable charges would be deposited in the Treasury as miscellaneous receipts and placed in a proprietary account. It is expected that this proposal will result in increased revenues of over \$650 million over the 3-year life of the provisions.

C. TITLE III—AID TO FAMILIES WITH DEPENDENT CHILDREN PROVISIONS

(1) *AFDC Quality Control*.—Minimum quality control policies and procedures would be established in statute as would a new national error rate standard of 3.5 percent. Adjustments to the standard would be made if the state operated an AFDC unemployed parents program, exceeded the national average in terms of percent of total state AFDC caseload with earnings and/or exceeded the national average in terms of population density.

Two adjustments would be made in the raw error rate data collected. First, technical errors would be excluded for fiscal sanctions purposes. Second, the point estimate of a state's error rate would be the lower bound of the range within which a state's true error rate falls, rather than the midpoint, if the state has a sample size sufficient to produce a lower limit of 2.5 percentage points or less than the midpoint. In the calculation of the lower confidence level, the Secretary would have the authority to promulgate regulations to adjust for variability among states in the number, proportion or dollar value of cases where the findings of the state quality control review differ from the Federal findings.

Fiscal sanctions would be imposed on the basis of the adjusted error rate and the adjusted state tolerance level. A sanction amount would be reduced by the Federal share of overpayments collected by the state in the fiscal year to which the error rate applies. In addition, the current authority for the HHS Secretary to waive sanctions under certain circumstances would be retained and expanded as proposed in H.R. 1279. The Committee deleted the Subcommittee provision which would have required the Federal government to reimburse states for errors it makes in administering the SSI program.

(2) *Teenage Pregnancy Block Grant*.—The Committee authorized a two-year grant program to permit the state AFDC agency to operate a two-part teenage pregnancy program:

(i) *Prevention Program for AFDC Families*.—These activities would be targeted to male and female children in AFDC fami-

lies and would include active parent participation. The program would address factors which have been shown to play important roles in determining teenage sexual activity and contraceptive use.

(ii) *Comprehensive Service Program or Teenage AFDC Parents*.—Participation would be voluntary; teenage parents who elect to participate would be required to seek a high school degree (or equivalent) and would receive services, including training, day care and transportation, to help them become self-sufficient and avoid long-term welfare dependence.

The program activities would be financed through a block grant to each state. The legislation authorizes the appropriation of \$50 million in fiscal year 1986 and \$100 million in fiscal year 1987. States would be entitled to receive a grant in each of the two fiscal years for which the program is authorized.

(3) *AFDC for Unemployed Two-Parent Families*.—Effective October 1, 1986, the current optional AFDC program for unemployed parents would be mandatory in all states. As a result, all states would aid needy two-parent families in which the principal earner is unemployed.

In addition, the definition of "quarters of work" would be modified to permit, at state option, the substitution of participation in school or training as follows: (1) school attendance would be limited to elementary or secondary school; (2) four quarters of vocational training could be substituted for four quarters of work; (3) attendance in school or vocational training would have to have been full-time; and (4) at least two of the six quarters must be quarters of work.

D. TITLE IV—RAILROAD UNEMPLOYMENT COMPENSATION AND OTHER UNEMPLOYMENT COMPENSATION PROVISIONS

(1) *Railroad Unemployment Compensation*.—The railroad unemployment repayment tax, which is designed to repay loans from the railroad retirement account to the railroad unemployment insurance account and scheduled to begin on July 1, 1986, is increased. The increase amounts to approximately \$200 million. The Committee also extended the authority of the unemployment account to borrow from the retirement account. An automatic surcharge of 3.5 percent is imposed in the event of such borrowing.

(2) *Federal Supplemental Compensation*.—The Committee bill allows unemployed individuals who lost FSC benefits because of service in the National Guard during a major disaster to receive such benefits.

E. TITLE V—REVENUE PROVISIONS

The revenue title of the bill includes five provisions, relating to: (1) Internal Revenue Service (IRS) budget for fiscal year 1986; (2) cigarette excise tax; (3) coal excise tax for the Black Lung Disability Trust Fund; (4) tax treatment of Railroad Retirement benefits; and (5) Pension Benefit Guaranty Corporation (PBGC) premiums. The first four provisions are estimated to increase net fiscal year budget receipts by \$7.0 billion for the three-year period, 1986-1988.

SUMMARY OF DEFICIT REDUCTION

The total deficit reduction achieved by the provisions summarized above, over the three-year period from 1986 to 1988, is \$19.1 billion, as shown in the following table. The deficit reduction target for the Committee on Ways and Means in the House-passed budget resolution, counting revenue from Superfund legislation which has yet to be considered by the Committee, is \$21.5 billion. The committee expects to act on Superfund legislation after the August recess.

Deficit reduction achieved from fiscal year 1986-88

	<i>Billions</i>
Medicare ¹	\$10.3
Trade ¹	1.8
Public Assistance and Unemployment Compensation ¹	² 4
Pension Benefit Guaranty Corporation Premium Increase6
Revenue Proposals	7.0
Total	19.2

¹ Also includes some revenue items.

² Number indicates an increase in outlays.

II. EXPLANATION OF PROVISIONS

TITLE I—MEDICARE AMENDMENTS

A. CHANGES RELATING PRIMARILY TO PART A OF THE MEDICARE PROGRAM

1. *Rate of increase in payments for inpatient hospital services (sec. 101 of the bill)*

Present law.—Current law provides that the medicare prospective payment rates should be updated annually by the Secretary of Health and Human Services. The law states that the update should reflect increases in hospital input prices but, for FY 1986, may not exceed the market basket (hospital input prices) plus one quarter of a percentage point.

The Secretary of HHS promulgated proposed regulations that would freeze DRG payments for FY 1986 at the FY 1985 levels. This regulatory initiative would save \$6.420 billion over three years.

Explanation of provision.—The bill would require that the Secretary provide a 1% increase to the DRG payments. A similar rate of increase would be provided for PPS exempt hospitals which remain on a cost reimbursement system.

The Committee, in deciding to provide for a 1% increase, has taken into consideration the errors made when the prospective payment rates were first established. The Congress required the Secretary to use the most recent available information when establishing the prospective payment rates in 1983. In complying with this requirement the Secretary used unaudited cost data in developing the PPS rates. The General Accounting Office has since determined that the unaudited 1981 cost reports overstated the actual costs incurred by hospitals in the base year by 4.39%.

Effective date.—The provisions would be effective for cost-reporting periods beginning during fiscal year 1986 for prospective pay-

ment system-exempt hospitals; and for discharges occurring during fiscal year 1986 for prospective payment system hospitals.

2. One-year extension of DRG transition (Sec. 102 of the bill)

Present law.—The Social Security Amendments of 1983 (P.L. 98-21) provided for a new prospective payment system for hospital inpatient services provided to medicare beneficiaries.

Current law provides for a three-year phase-in or transition from hospital specific to national DRG (diagnosis-related group) rates. During this period a declining portion of each hospital's total prospective payment will consist of a hospital-specific payment (HSP), based on its historical reasonable costs, and an increasing portion will be based on a combination of regional and national DRG rates. In the fourth year of the program and thereafter, medicare payments will be determined under a totally national DRG payment methodology. The change in the historical cost/Federal DRG payments are made on a hospital's cost reporting period basis.

The Federal DRG component is comprised, for the first three years, of a combination of Federal and regionally determined rates. This phase-in recognizes the historical differences in hospital costs among regions of the country. Thus, different regional payment levels are provided for nine census divisions of the United States. Changes in the regional/national component of the Federal DRG are made on the Federal fiscal year basis.

The DRG payment rate phase-in started with each hospital's first cost reporting period which began on or after October 1, 1983. Below is the transition schedule under current law:

For hospital cost reporting periods beginning on or after:

10/1/83—75% HSP/25% DRG (100% regional);

10/1/84—50% HSP/50% DRG (75% regional/25% national);

10/1/85—25% HSP/75% DRG (50% regional/50% national);

10/1/86—100% DRG (100% national).

Explanation of provision.—The bill would extend the transition period for one additional year. The 50% hospital specific cost/50% Federal DRG blend would be maintained for FY 1986. The schedule would therefore be:

For hospital cost reporting periods beginning on or after:

10/1/84—50% HSP/50% DRG (75% regional/25% national);

10/1/85—50% HSP/50% DRG (75% regional/25% national);

10/1/86—25% HSP/75% DRG (50% regional/50% national);

10/1/87—100% DRG (100% national).

The prospective payment system is phased-in over a three-year period to give hospitals time to make adjustments to the new PPS system. Under the PPS system, hospitals with costs in excess of the medicare payment are forced to absorb the loss, while hospitals with costs below the medicare payment are permitted to keep the savings.

This provision would have two effects. First, it would continue, for one more year, to base 50% of the payment on the hospital's own historical costs. Second, it would continue, for one more year, to base 75% of the payment on regional costs.

The Committee believes that this additional transition year would give all hospitals more time to adjust to the prospective payment system. In addition, it would provide hospitals in higher cost

regions of the country an opportunity to make the necessary changes to reduce their costs.

The Committee is committed to the prospective payment system under medicare. This one-year delay in the transition to national rates does not reflect a lack of support for the prospective payment system but rather a concern that the three-year transition from cost reimbursement to national DRG rates is an inadequate period of time for higher cost hospitals, especially in higher cost regions of the country, to reduce their costs to the national average.

Furthermore, the Committee expects that over the next year significant progress will be made in developing refinements to the DRG system to more accurately reflect the actual costs incurred in providing care. For example, the Committee, in this legislation, has requested a report on refining the hospital wage index to reflect the higher costs incurred in core city areas relative to suburban areas. In addition, the Committee anticipates that significant progress will be made toward implementing a severity of illness index.

Effective date.—For the Federal DRG portion (i.e. retaining the 75/25 regional/national component for one more year), the provision would be effective for discharges occurring in Federal fiscal year 1986. For the hospital specific/DRG component (i.e. retaining the 50/50 HSP/DRG payment) the provision would be effective for hospital cost reporting periods beginning on or after October 1, 1985.

3. Application of revised hospital wage index (sec. 103 of the bill)

Present law.—As an integral part of the medicare prospective payment system (PPS) for hospitals, the Federal portion of the prospective payment rates is adjusted to take into account differences in wages from area to area. This is accomplished by means of an area wage index applied to all PPS hospitals in urban and rural areas. The current hospital wage index is constructed from a national data base of hospital wage records maintained by the Bureau of Labor Statistics (BLS). There are a number of technical flaws in this index, principally that it fails to recognize local differences in the number of part-time workers hospitals employ.

Because of inaccuracies in the BLS wage index, the Secretary was required to report to Congress on a refined area wage index. The report outlined two alternative wage indices based upon a survey of over 5,000 hospitals. The Department of Health and Human Services has included in its proposed PPS regulations for the coming fiscal year the adoption of one of these indices, the "gross hospital wage index." This index is derived from total gross hospital wages, including salaries of interns and residents, hospital-based physicians, and all other wages and salaries paid to hospital employees.

Present law specifies that any new wage index be implemented retroactively to October 1, 1983.

Explanation of provision.—The bill would require the Secretary to implement the new gross wage index promulgated in the proposed regulations published June 10, 1985, effective for October 1, 1985. The present law requirement of retroactive application of the new wage index would be repealed. The bill would require that the

gross wage index be used for discharges occurring during FY 1986. The Committee intends to give the Secretary flexibility to make further refinements in the area wage index for FY 1987 and beyond.

By requiring that the hospital wage gross index, as described in the proposed regulations of June 10, 1985, be adopted, the Committee does not wish to preclude the Secretary from making adjustments to reflect computational errors that may have been made in calculating the specific index amounts.

The Secretary would be required to study and report to the Congress recommendations on refining the area wage adjustment to reflect the higher wage costs incurred by central city areas relative to suburban areas of the same metropolitan area.

Effective date.—The bill would be effective for discharges occurring during FY 1986 and thereafter.

4. Change in formula for indirect teaching adjustment (sec. 104 of the bill)

Present law.—The medicare program has always provided reimbursement for both the direct and indirect costs of medical education incurred by teaching hospitals. The direct costs of approved medical education programs (such as salaries for residents and teachers and classroom costs) are excluded from the prospective payment system, and are reimbursed on a reasonable cost basis. The indirect costs are increased patient care costs associated with teaching programs due to such factors as increased diagnostic testing, increased numbers of procedures prescribed, higher staffing ratios and a more severely ill patient population.

These indirect costs have been estimated statistically for the purposes of adjusting medicare payments on a prospective basis. The increases in payments vary directly with each hospital's ratio of interns and residents to its number of beds (IRB). Specifically, the Health Care Financing Administration has estimated, on a linear basis, that a 0.1% increase in IRB ratio would result in a 5.79% increase in medicare's cost per discharge.

When Congress passed the prospective payment system it established the indirect teaching adjustment factor at 11.59%—double the original estimate. This adjustment is made to the Federal DRG portion only. The adjustment was doubled because, in aggregate, teaching hospitals received lower payments under the DRG system than under the cost-based system. Additional concern that the DRG system would adversely affect teaching hospitals stemmed from doubts about the ability of the DRG case classification system to fully account for factors such as severity of illness, urban location, bed size and increased medicare costs associated with hospitals that serve large numbers of low-income patients. The doubling of the indirect teaching adjustment from 5.79% to 11.59% was done on a budget-neutral basis. The DRG payments were adjusted downwards overall to account for the doubling of the indirect teaching adjustment.

The Administration's FY 1986 budget includes a provision which would reduce the indirect teaching adjustment by half, to 5.79%. This would save \$2.9 billion over three years.

Explanation of provision.—The provision would reduce the indirect teaching adjustment to 8.1% (for FY 1986 and FY 1987) and 8.7% (for FY 1988 and beyond) for each 0.1 increase in the IRB ratio on a variable basis. The data reviewed by the Committee show clearly that the 11.59% indirect teaching adjustment is too high, and that the appropriate adjustment is 8.7%. Also, CBO has estimated that medicare costs increase at a slower rate as teaching programs get larger. Therefore, the current method of using a constant adjustment for each 0.1 increment in the IRB ratio may over compensate those hospitals with the highest IRB ratios. CBO estimates indicate that an adjustment made on a variable basis would better reflect the non-linear cost relationship. Therefore, the Committee bill provides for a curvilinear adjustment.

The Committee has also approved an adjustment to hospitals serving a disproportionate share of low-income patients for fiscal years 1986 and 1987. The data reviewed by the Committee support a lower indirect teaching adjustment if a disproportionate share adjustment is provided. The lowering from 8.7% to 8.1% recognizes that a portion of the indirect teaching adjustment compensates hospitals serving a disproportionate share of low-income patients. When the disproportionate share provisions expire at the end of FY 1987 the indirect teaching adjustment would revert to 8.7%.

The savings from the reduction in the indirect teaching adjustment from 11.59% on linear basis to 8.7% on a curvilinear basis would be total systems savings taking into account variations in indirect teaching payments across regions. The savings from the further reduction from 8.7% to 8.1% would be retained in the payment pool to offset the additional costs of the disproportionate share provision.

The Committee has stated the specific indirect teaching adjustment formula in the law. There is no discretion on the part of the Secretary. Furthermore, the Committee bill requires that the Secretary continue to count, for purposes of establishing the IRB ratio, those interns and residents who serve in the outpatient departments of hospitals. This would prohibit the Secretary from implementing the change in counting promulgated in proposed regulations published June 10, 1985. The change proposed by the Administration on the IRB count are technically incorrect because the regression analysis used to compute the adjustment factor was based on counts that included the interns and residents in hospital-based outpatient settings.

Effective date.—The provision would be effective for discharges occurring on or after October 1, 1985.

5. *Computation of additional payment amounts for hospitals serving a disproportionate share of low-income patients (Sec. 105 of the bill)*

Present law.—Under the Social Security Amendments of 1983 the Secretary of HHS was required to make such adjustments to the PPS rates as the Secretary deems appropriate for hospitals that serve a disproportionate number of low-income or medicare patients. The Deficit Reduction Act of 1984 also required the Secretary, prior to December 1, 1984, to develop and publish a definition of disproportionate share hospitals, to identify such hospitals, and

to make the list available to the Committees with legislative jurisdiction over part A of medicare. The Secretary has to date failed to develop criteria for defining or identifying such hospitals or otherwise make information available to the Committees.

Explanation of provision.—The bill would require the Secretary of HHS to make additional payments on the Federal portion of the DRG payment, for urban PPS hospitals with 100 beds or more, serving a disproportionate share of low-income patients. The proxy measure for low-income would be the percentage of a hospital's total patient days attributable to medicaid patients (including medicaid-eligible medicare beneficiaries—medicare/medicaid cross-overs). The Federal DRG payment would be increased by .7 percent for each 1 percentage point increase in the ratio of low-income inpatient days to total inpatient days, above the minimum threshold of 15%. The maximum adjustment would be no greater than 16%.

A limited exceptions process would be established for urban PPS hospitals with 100 beds or more. The Secretary would be required to make disproportionate share payments where a hospital can demonstrate that at least 30% of its net inpatient care revenue is provided by local or state governments for inpatient care for low-income patients not otherwise reimbursed by medicaid. If this threshold is met the per DRG add-on would be 16%.

Despite several mandates in the law, the Secretary continues to fail to implement a disproportionate share adjustment in any meaningful way. This total lack of responsiveness on the part of the Secretary has forced the Committee to go to the considerable length of mandating a specific adjustment to the PPS system to provide additional payments to disproportionate share hospitals. The Committee's concern for disproportionate share hospitals has increased as the PPS system continues to phase in. The Prospective Payment Assessment Commission also views this adjustment as a high priority for implementation in FY 1986. Considering all these facts, the Committee decided to proceed to develop an adjustment based upon the best available information. The Committee felt that any reasonable adjustment that could be implemented in FY 1986 would be better than none.

Hospitals that serve a disproportionate share of low-income patients have higher medicare costs per case. There are two categories of reasons for these increased costs: a) low-income medicare patients are in poorer health within a given DRG (that is, they are more severely ill than average), tend to have more complications, secondary diagnoses and fewer alternatives for out of hospital convalescence than other patients; b) hospitals having a large share of low-income patients (medicare and non-medicare) have extra overhead costs and higher staffing ratios which reflect the special need for such personnel as medical social workers, translators, nutritional and health education workers. These hospitals are frequently located in central city areas and have higher security costs. They often serve as regional centers and have high standby costs for trauma units, burn units, psychiatric emergency services, neonatal intensive care units and poison control units. They are often recipients of economic transfers of high cost low-income patients from other hospitals.

The conclusion that certain hospitals serving a disproportionate share of low-income patients have higher costs per case is supported by data and analysis from the Congressional Budget Office, the Prospective Payment Assessment Commission, the Health Care Financing Administration, the American Hospital Association and the Urban Institute.

Based on comprehensive analysis of cost data, the Committee determined that the only hospitals that demonstrated a higher medicare cost per case associated with disproportionate share of low-income patients were urban hospitals with over 100 beds. The Committee carefully reviewed all the information relating to rural hospitals. Based on all the data available to the Committee, there was no evidence to indicate that medicare costs per case were higher in rural hospitals serving a disproportionate share of low-income patients. Since the rationale for making the disproportionate share adjustment is related directly to higher medicare costs per case, the Committee concluded that, based on available data, there was no justification for making these payments to rural hospitals, or to urban hospitals with fewer than 100 beds.

The Committee has explicitly required that the Secretary make additional payments for disproportionate share urban hospitals with over 100 beds for discharges occurring in FY 1986 and FY 1987. There is no discretion on the part of the Secretary.

In developing the adjustment, the Committee searched for a proxy measure for low income. The Committee reviewed available information from the American Hospital Association and other sources and determined, after extensive review, that use of the medicaid days as a proxy most accurately reflected the factor the Committee was trying to measure, the presence of low-income patients. The Committee did not want to impose any additional administrative requirements on hospitals or patients. Therefore, the Committee rejected any direct measures of the income of patients. Furthermore, the proxy measure chosen can easily be implemented for FY 1986.

The Federal DRG payment would be increased by .7% for each one percentage point increase in the ratio of low-income inpatient days to total inpatient days, above a minimum threshold of 15%. If a patient is eligible for medicaid at any point during his inpatient stay, all days of care attributable to that patient would be counted under the provision, whether or not actually paid for by the medicaid program. In no case would a hospital receive an adjustment greater than 16%. If a Hospital qualified for the maximum under this provision or under the exception provision described below, the per DRG payment would be increased by 16%.

The Committee provided for a sunset of the disproportionate share provision after two years. In providing for the sunset the Committee anticipates that refinements in the PPS system would be implemented that would limit the need for such a disproportionate share adjustment; examples of such refinements might be a refined area wage index to reflect the higher wage costs of central city areas relative to suburban areas and an adjustment for severity of illness.

The indirect teaching adjustment in this bill was reduced from 8.7% to 8.1% to reflect the disproportionate share adjustment.

When the disproportionate share adjustment expires in two years, the indirect teaching adjustment would be increased for FY 1988 and beyond to 8.7%.

The Committee believes that the Secretary should interpret the 100-bed threshold narrowly, that is, that the beds that should be counted should be staffed and available beds. The bed count would reflect beds staffed and available in the cost reporting period immediately prior to the cost reporting period for which the adjustment would be made.

The disproportionate share provision would be budget neutral. Both the indirect teaching adjustment and the disproportionate share provision require a restandardization of the standardized payment amounts. In order to ensure that the budget neutrality calculation does not redistribute payment amounts among the twenty payment areas for which standardized payment amounts are calculated, the budget neutrality adjustment should be calculated to take into account the varying teaching payments in each of these regions. For each of these twenty payment areas, indirect teaching payments based on rates standardized to 8.1% curvilinear and paid out on the same basis plus the disproportionate share payments, shall be neither more nor less than the payments based on rates standardized by 11.59% linear indirect medical education factor and paid out on 8.7% curvilinear basis. It is the intent of the Committee that the term "budget neutral" as applicable to this provision for FY 1986 and 1987 implies that total payments should be no more and no less than would have occurred if the only change were to reduce the indirect teaching adjustment to 8.7 percent on a curvilinear basis. That is, the reduction in the indirect teaching adjustment from 8.7 percent to 8.1 percent must be used to partially offset the cost of the disproportionate share adjustment. The remaining disproportionate share cost would be reflected in lower standardized amounts.

Because of concern that this proxy measure of low-income status might substantially understate the presence of low-income patients in some hospitals, most particularly public hospitals in states where the medicaid eligibility standards are stringent, this provision also includes a limited exceptions process for such hospitals. This exceptions process would require the Secretary to make disproportionate share payments of 16% per DRG on the Federal portion where the hospital can demonstrate that 30% or more of its net inpatient care revenue is provided directly or indirectly by local or State governments for inpatient care not otherwise reimbursed by medicaid. Hospitals account for their State and local inpatient care appropriations in various ways. Some hospitals receive patient-specific payments in addition to more general direct or indirect subsidies. The Secretary would be required to include all such inpatient care payments in determining whether a hospital meets the threshold for the exception. The Committee does not intend for hospitals to include appropriations not related to inpatient care operating costs. The Committee further intends that the denominator of this equation, net inpatient care revenue, be defined according to the generally accepted accounting principles in the hospital industry; i.e., this factor should represent gross patient care revenues

less deductions from revenue (other than contractual allowances), as those terms are generally used.

The Committee believes that the exceptions process is very limited and the Secretary should ascribe relatively small costs to be associated with the exceptions process. Since the adjustment is on a budget-neutral basis, any over-estimate of the cost of the exceptions process will result in lower standardized payment amounts.

The Committee anticipates that the disproportionate share payments would be paid to hospitals on an interim payment basis with settlement at the end of the hospital's cost reporting period. This is the same method other payments are made under the medicare program.

The Committee understands that to implement the indirect teaching adjustment, the disproportionate share adjustment and the new wage index may require the use of data from different time periods.

Effective date.—Discharges occurring between October 1, 1985 and September 30, 1987.

6. Treatment of certain rural osteopathic hospitals as rural referral centers (sec. 106 of the bill)

Present law.—Under present law, rural hospitals that meet certain requirements can qualify to receive the "urban" standardized payment amount adjusted by the rural wage index that applies for the geographic area. The adjustment was permitted because data indicated that large rural hospitals with high case-mix indices had cost experiences similar to those experienced by urban hospitals.

In order to qualify as a rural referral center under current regulations, a hospital must have or exceed a specified minimum case-mix index, have at least 6,000 discharges in a cost-reporting period and meet other requirements. Under these criteria, approximately 146 rural hospitals qualify as rural referral centers. The Health Care Financing Administration reviews each rural referral center every three years to determine whether the hospital continues to qualify.

Explanation of provision.—The bill would allow osteopathic hospitals to qualify as rural referral centers if they have at least 3,000 discharges in a cost-reporting period and meet all the other requirements, as specified by the Secretary, for rural referral center designation.

Effective date.—Effective for cost reporting periods beginning on or after the date of enactment.

7. One-year prohibition on freezing cost increases that may be recognized for direct medical education (sec. 107 of the bill)

Present law.—Medicare has historically reimbursed teaching hospitals on a cost basis for its share of the direct costs of approved medical education activities.

On July 5 of this year, the Administration issued final regulations freezing the amount medicare will reimburse providers for their direct costs of approved medical education activities, for cost reporting periods beginning on or after July 1, 1985.

The freeze permits payment based on the lesser of a provider's allowable direct medical education costs for the current cost report-

ing period or for a base year (the provider's cost reporting period beginning on or after October 1, 1983), adjusted for changes in medicare utilization.

Explanation of provision.—The Committee bill would prohibit the Secretary from implementing the regulations that impose the one-year freeze on medicare payment for the direct costs of approved medical education activities.

The Committee views the freeze as a regulatory action driven by budgetary considerations which are not within the scope of factors the Secretary may consider in making reasonable cost determinations.

The Committee recognizes a need to re-examine Federal policy regarding support of medical education programs through the medicare trust funds, and may wish to legislate in this area next year.

Effective date.—The provision would be effective retroactively to July 1, 1985.

8. *Return on equity capital for inpatient hospital services and other services (sec. 108 of the bill)*

Present law.—A return on equity (owner) capital invested and used in providing patient care is considered a medicare allowable cost for proprietary, or for-profit, health care providers. Equity capital is the net worth of a hospital excluding those assets and liabilities not related to patient care. Specifically, equity capital includes: (1) the investment in the plant, property, and equipment (net of depreciation) related to patient care, plus deposited funds required in connection with leases; and (2) net working capital maintained for necessary and proper operation of patient care facilities.

The level of payment for return on equity (ROE) formerly was set at a rate of no more than one and one-half times the average rate of return on trust fund investments. In the 1983 social security amendments, the Congress reduced the level of payment for ROE with respect to reasonable costs of inpatient hospital services to the average rate of return on trust fund investments. The rate of return for other provider services was not affected.

Explanation of provision.—Beginning October 1, 1986, return on equity would no longer be a medicare allowable cost for inpatient hospital services. In addition, costs attributable to a return on equity capital would not be included in determining national and regional adjusted DRG prospective payment rates.

The Committee believes that under the prospective payment system hospitals should earn rather than be guaranteed a profit (or surplus). Hospitals that operate efficiently and economically can earn a profit under the prospective payment system and do not need a medicare-guaranteed return on equity. Further, the Committee believes that the prospective payment system's recognition of capital-related costs should be applied evenly to all hospitals. Return on equity capital for proprietary hospitals should not be included.

Beginning October 1, 1985, the bill would reduce the rate of return for other provider services, if regulations provide for ROE, to the average rate of return on the hospital insurance trust fund.

Effective date.—For inpatient hospital services, the provision would be applicable to cost reporting periods beginning on or after

October 1, 1986 and to DRG payments for discharges on or after October 1, 1986.

For other provider services, the provision would be applicable to cost reporting periods beginning on or after October 1, 1985.

9. Continuation of medicare reimbursement waivers for certain hospitals subject to regional hospital reimbursement demonstrations (sec. 109 of the bill)

Present law.—Under present law, normal medicare reimbursement rules may be waived for demonstration projects. When research is completed, the normal medicare reimbursement rules are reinstated.

Explanation of provision.—The bill would allow a local hospital reimbursement control system that had operated under a medicare waiver to continue if the State requests the continuation and if the local project meets condition imposed Statewide on States that receive a waiver.

Such a system would be required to include substantially all acute care hospitals in its area and review at least 75 percent of all revenues or expenses in that area for inpatient hospital expenses and 75 percent of revenues or expenses in the area for inpatient hospital services provided under the State's plan approved under title XIX. Medicare's costs could not exceed what they otherwise would be under the medicare PPS system.

This option would be available only to reimbursement systems that were carrying out a demonstration on January 1, 1985 and had been approved by the Secretary of Health and Human Services. The Committee's provision reflects the view that hospital reimbursement control systems, such as that operating in the Rochester, New York area, that began as research-oriented demonstration projects, should be allowed a continued waiver if they achieve the requisite savings.

Effective date.—The provision would be effective upon enactment.

10. Four-year test for state waivers for certain states (Sec. 110 of the bill)

Present law.—Under present law states may request a waiver of medicare's reimbursement rules for a statewide hospital reimbursement control system under Section 1886(c) of the Social Security Act. A number of requirements must be met before such a waiver request is granted. One requirement is that the State demonstrate, to the Secretary of HHS's satisfaction, that the amounts of payments made under the waiver would not exceed the amounts that otherwise would have been paid with respect to a 36-month period under Title XVIII if the state were not under a statewide reimbursement waiver.

Explanation of provision.—The provision would extend the 36-month test period under section 1886(c)(1)(C) for a further 12 months. Therefore the comparison period would be a 48-month period. The provision would apply only to States which had made a request for a waiver under 1886(c) prior to December 31, 1984. The only state that meets these criteria is New Jersey.

The Committee has repeatedly reaffirmed the value of State reimbursement control systems. In the Social Security Amendments of 1983, the Secretary was required to approve State applications for statewide alternative payment systems, as long as they meet certain conditions. The key condition, expressed in Section 1886(c)(1)(C), is a cost-effective test—the State must be able to assure the Secretary that medicare payments under the State system are projected for a 36-month period to be no greater than they would be using medicare's own rules.

The Committee does not intend that its action in delaying the DRG transition in the prospective payment system should jeopardize these systems. Specifically, the Committee wants to avoid the situation in which the delay in the transition changes the calculation of what medicare would otherwise pay to such an extent that an otherwise effective State reimbursement control system becomes unable to meet the cost-effectiveness test during the current 36-month period.

The Committee's amendment would add a fourth year to the cost-effectiveness test for certain State systems approved under Section 1886(c). The Secretary is directed not to terminate any approved system, for failure to meet the cost-effectiveness criteria, so long as the State takes appropriate steps by July 1, 1986, to assure the Secretary that its system will continue to meet the cost-effectiveness test, applied over a 48-month period.

The Committee also expects the Secretary to continue monitoring payments and other oversight programs as set forth in the waiver agreements to ensure that systems comply with all statutory standards and other agreed-to terms and conditions, except that the monitoring plan may be revised to reflect the revision of data submitted, as a basis to assure the Secretary that the cost-effectiveness requirements, as modified, are met.

Effective date.—The provision would be effective upon enactment.

11. Special rule for treatment of depreciation and capital indebtedness for donations of state property to non-profit corporations (sec. 111 of the bill)

Present law.—Section 2314 of the Deficit Reduction Act limited the basis for which medicare depreciation is allowed when a change of ownership occurs. The new owner basis is the lesser of (1) historical cost (cost to the original owner) or (2) the purchase price.

Explanation of provision.—The bill would provide a special rule for treatment of certain transfers. In the case of an asset that is donated by a State government (donor) to a non-profit corporation (donee) the basis from which capital-related costs to the donee is calculated would be the lesser of the donor's historical cost (net of depreciation) or the fair market value.

The Committee was concerned that donated assets would be subject to the limitation enacted in DEFRA. The Committee believes that it is appropriate to allow the donee to receive the depreciable basis of the donor. The Committee is merely continuing the policy regarding donation of assets as contained in regulations.

The Committee intends that the Secretary provide exceptions to the revaluation of asset provision for non-profit organizations who

obtain ownership of a State owned general acute care hospital for nominal consideration. The exception would provide that the basis for which capital-related costs are determined to the non-profit organizations would be the prior owner's historical cost (net of depreciation).

Effective date.—The provision would be effective as if it had been originally included in the DEFRA.

12. Report on impact of outlier and transfer policy on rural hospitals (sec. 112 of the bill)

Present law.—Present law requires that additional payments be made under the prospective payment system for hospitals when there is either an unusually long length of stay or the stay is excessively costly (both as defined by the Secretary). Regulations of the Secretary prescribe rules for PPS payment in cases where patients are transferred between hospitals.

Explanation of provision.—The Secretary of Health and Human Services would be required to review the impact of the outlier and transfer policies under the PPS system especially as they relate to rural hospitals with less than 100 beds.

The Secretary would be required to report to Congress on the findings of the review not later than March 1, 1986, and should include in this report recommendations on changes in these policies to the extent that they adversely affect rural hospitals.

Effective date.—The provision would be effective upon enactment.

13. Information on impact of PPS payments on hospitals (sec. 113 of the bill)

Present law.—Under the Congressional Budget Act of 1974, the Congressional Budget Office (CBO) is entitled to the most recently available cost reports submitted by medicare participating hospitals to the Department of Health and Human Services. There is no requirement that the House of Representative's Committee on Ways and Means or the Senate's Committee on Finance receive cost report information on hospitals that participate in the medicare program.

Explanation of provision.—The bill would require the Secretary of Health and Human Services to make available to the Prospective Payment Assessment Commission (ProPAC), the Congressional Budget Office, and to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate the most current information on the payments being made under the prospective payment system to individual hospitals.

The hospital specific information would be treated as confidential and would not be subject to further disclosure in a manner that would permit the identification of individual hospitals.

There has been a great deal of concern that the Department of Health and Human Services has not submitted hospital cost report and medicare payment information from hospitals participating in the medicare program in the most timely fashion. As a result, CBO has not had enough time to properly analyze proposals under consideration by this Committee. Further, the Committee has been frustrated in its attempts to fully understand the impact of the

new prospective payment system on hospitals in different areas of the country, or on specific categories of hospitals that participate in medicare, because it has lacked data available to the Department of Health and Human Services. In order to more effectively legislate in this area the Committee believes that it needs more comprehensive data.

Effective date.—The provision would be effective upon enactment.

14. Extension and payment for hospice care (sec. 121 of the bill)

Present law.—Under current law, individuals who are entitled to medicare part A benefits and who are certified to be terminally ill may elect to receive part A reimbursement for hospice care services, in lieu of certain other services. Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which authorized this hospice benefit, mandated reports to the Congress by the Secretary of Health and Human Services on September 30, 1983 (regarding the Department's hospice demonstration project) and January 1, 1986 (evaluating the hospice benefit). Current authority for the medicare hospice benefit is scheduled to sunset on October 1, 1986.

In implementing the TEFRA hospice benefit, the Department of Health and Human Services established a prospective payment system and set daily rates for each of four levels of hospice care. Public Law 98-617 increased the routine home care payment rate by approximately \$7.00 per day for the fiscal year beginning October 1, 1984, and required the Secretary of HHS to review and adjust the hospice rates annually, beginning October 1, 1985.

The report on the hospice demonstration project, which was to have been submitted by September 30, 1983, has not yet been received by the Congress, and it is clear that no comprehensive evaluation of the hospice benefit will be available for review by the Congress prior to October 1, 1986. In addition, it appears that meaningful cost data will not be available to the Secretary in order for the rates to be updated by October 1, 1985.

Explanation of provision.—The bill would repeal the sunset provision of present law. Beginning October 1, 1985, each of the daily payment rates for hospice care would be increased by \$10.00, an amount which is slightly less than the Congressional Budget Office estimate of the savings per day attributable to a medicare hospice election. The Secretary would be given one additional year, until October 1, 1986, to review and adjust the hospice rates and to report to the Congress on the adequacy of the rates in insuring participation in medicare by an adequate number of hospice programs.

Effective date.—The repeal of the sunset provision would be effective on enactment of the bill and the rate increases would be effective for hospice care furnished on or after October 1, 1985.

15. Limiting the penalty for late enrollment in part A (sec. 122 of the bill)

Present law.—Under present law, part A coverage under medicare is available on a voluntary basis to individuals 65 or over who are not otherwise entitled to coverage. These individuals may obtain medicare part A coverage by paying a monthly premium.

Anyone purchasing part A coverage after the third month after the month in which he becomes eligible is charged a late penalty of 10% of the standard premium for each 12 months he is late in enrolling; that is, for each 12 months during which he could have been, but was not enrolled. This penalty is paid each and every month of coverage for the rest of the beneficiary's life.

Explanation of provision.—The Committee believes that these premium penalty provisions are too severe. They can involve large percentage increases in premium amounts which, by themselves, are quite large. The bill would limit the part A premium penalty to 10% no matter how late an individual enrolled, and the period during which the penalty is paid would be limited to twice the number of years enrollment was delayed. At the end of this period, the premium would revert to the standard monthly premium in effect at that time. For example, if the individual enrolled one year late, the penalty would be 10%, paid for two years; for late enrollment for two years, the penalty would be 10% a year for four years, and so on, after which it would revert to the standard premium amount.

The bill would also apply to medicare beneficiaries currently paying a part A premium penalty. Months before, during or after January 1986, in which such an individual was required to pay a premium penalty, would be taken into account in determining the month in which the premium would no longer be subject to a penalty increase.

Effective date.—The provision would apply to premiums payable for January 1986, and thereafter.

16. Medicare coverage of, and application of hospital insurance tax to, newly-hired state and local government employees (sec. 123 of the bill)

Present law.—Most State and local government employment is covered under social security (for social security monthly benefits and medicare) as a result of voluntary agreements for such coverage entered into by the States. This coverage is not mandatory, but governmental units whose employees have such coverage are not permitted to withdraw their employees from coverage. Some 25-30 percent of State and local employment is not covered under social security.

Explanation of provision.—Individuals who have worked in State and local government employment that is excluded from social security coverage are often able to acquire insured status and thus to qualify for social security and medicare benefits nonetheless. They qualify as a result of work performed in other employment covered under the program or through the entitlement of a spouse. It is estimated that perhaps 95 percent of all State and local employees eventually qualify for benefits. By and large, individuals who qualify after having worked in excluded State and local government employment have contributed significantly less in social security FICA taxes than others who become entitled to benefits. They therefore represent a financial drain on the system, and especially on the medicare hospital insurance program.

Unlike monthly social security benefits, where minimal covered earnings and tax contributions result in minimal benefit amounts

entitlement to medicare is entitlement for the full range of benefits. The benefits are the same regardless of whether the insured worker has made significant tax contributions over his working lifetime or whether he has qualified with the minimum number of quarters of coverage. The Committee believes that the time has come to begin the correction of this problem as it relates to the medicare program.

Accordingly, the Committee bill would extend medicare coverage on a mandatory basis for newly-hired employees of State and local government entities. The employers and their employees would become liable for the hospital insurance portion of the FICA tax and the employees would earn credit toward medicare eligibility based on their covered earnings. Mandatory coverage would be extended only for medicare and only for employment not otherwise covered under voluntary State coverage agreements.

The Committee believes that the future medicare entitlement of State and local government employees will in many cases have the effect of reducing the costs of existing health benefit programs for employees and retirees of the affected governmental entities. Nonetheless, the Committee is aware of concerns among State and local governments about the financial burden that mandatory medicare coverage for all their employees might represent. Accordingly, the extension of mandatory coverage would be applicable to employees hired on or after January 1, 1985.

The Committee anticipates that the Secretary of the Treasury will issue regulations relating to the collection of the new mandatory FICA taxes with respect to State and local government employment and relating to the technical rules under which it will be determined whether an individual employee is newly hired and thus covered, or has in fact not been separated from his previous excluded employment and thus remains excluded from mandatory coverage.

The Committee recognizes that in many cases where few employees of a State and its local jurisdictions have previously participated in social security, the pressure will be great to seek to avoid coverage under this provision. The provision exempts from coverage only employees of State and local governments, legitimately employed by those governments prior to January 1, 1986. The Committee expects that the Internal Revenue Service will carefully scrutinize the circumstances of those claiming to be exempt whose employment connection with the State or local entity prior to January 1, 1986, appears tenuous or questionable.

The Committee also recognizes that defining entities as separate employers for purposes of determining whether an employee has been hired by a State or local entity after 1985, may pose complex issues for the Internal Revenue Service. It should be generally true that employees who move between different jobs in different integral units of a State government, such as different departments within the State government, would be considered continuously employed by the State, while employees who move from State government employment to a job with a local township, county or municipality, or vice versa, would be considered to be newly hired. The Committee expects that cases in which the distinctions are

more difficult to make will be judged according to the independence of the second employing unit from the first, as an employer.

Effective date.—The provision is effective with respect to service performed after December 31, 1985 by employees hired by a State or local government after that date.

17. Responsibilities of medicare hospitals in emergency cases (sec. 124 of the bill)

Present law.—Under current law, hospitals that participate in medicare have to meet defined conditions of participation and enter into participation agreements. There are no specific requirements relating to the appropriate treatment of emergency patients, including non-medicare patients.

Explanation of provision.—The Committee is greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if the patient does not have medical insurance. The Committee is most concerned that medically unstable patients are not being treated appropriately. There have been reports of situations where treatment was simply not provided. In numerous other instances, patients in an unstable condition have been transferred improperly, sometimes without the consent of the receiving hospital.

There is some belief that this situation has worsened since the the prospective payment system for hospitals became effective. The Committee wants to provide a strong assurance that pressures for greater hospital efficiency are not to be construed as license to ignore traditional community responsibilities and loosen historic standards.

All participating hospitals with emergency departments would be required to provide an appropriate medical screening examination for any individual who requests it (or has a request made on his behalf) to determine whether an emergency medical condition exists or if the patient is in active labor.

All participating hospitals must, when a patient is found to have an emergency condition or to be active labor (1) provide further examination and treatment within their competence to stabilize the medical condition or provide treatment for the labor, unless such treatment is refused or (2) provide an appropriate transfer to another medical facility in accordance with a defined standard.

A hospital may not transfer or discharge a patient who has not been stabilized or is in active labor unless: (1) there is a written determination by a physician based on the information available at the time and using reasonable standards that the benefits to be obtained from appropriate medical treatment at another facility outweigh the risks of transfer and (2) that the receiving facility has agreed to accept the patient, has space and qualified personnel available for his treatment and is provided with medical examination and treatment records from the transferring hospital. The transfer must be made by proper personnel using equipment that meets health and safety standards.

A hospital that fails to meet these requirements may have its medicare participation agreement terminated or be subjected to civil money penalties of not more than \$25,000 for a knowing viola-

tion of this provision. Any person or entity adversely and directly affected by a participating hospital's violation of these requirements may bring an action, in an appropriate state or Federal district court, for damages to the person arising from the violation and for other relief as may be appropriate to remedy the violation or deter subsequent violations.

A physician who has professional responsibilities for the provision of a screening examination or for the treatment of a patient, who knowingly fails to meet his responsibilities, as discussed below, will be subject to criminal penalties including a fine of not more than \$100,000 or up to a year in prison or both, or, if the patient dies as a direct result of this failure, a fine or not more than \$250,000 and a prison term of not more than five years, or both.

Criminal sanctions may be invoked if:

(1) the physician knowingly fails to provide for a screening examination in the emergency department if the failure represents a gross deviation from the prevailing local standards of medical practice or if the screening examination is conducted in a manner that is so inappropriate so as to represent a gross deviation from the prevailing local standards of medical practice, or

(2) the physician responsible for treatment knows or has reason to know that a patient has an emergency medical condition or is in active labor and knowingly—

(a) fails to provide for treatment to stabilize the patient if the failure represents a gross deviation from prevailing local medical practice or provides for treatment in a manner that is so inappropriate as to represent a gross deviation from prevailing standards of local medical practice; or

(b) orders the patient who has not been stabilized to be transferred other than to a medical facility, or to a medical facility that does not have space available and has not agreed to accept the patient.

Effective date.—The provision would be effective October 1, 1985.

B. Changes Relating to Parts A and B of the Medicare Program

1. *Extension of working aged provisions to individuals over 69 (sec. 131 of the bill)*

Present law.—The Age Discrimination in Employment Act (ADEA) requires employers of 20 or more people to offer employers and their spouses age 65 through 69 the same health insurance coverage they offer to their younger employees and under the same conditions.

If the older employee chooses the employer's plan, medicare becomes the secondary payor if the employer plan does not pay full benefits.

If the older employee chooses not to participate in the employer's plan, medicare will be the primary payor. The employer is prohibited from offering a health plan designed to supplement medicare, (i.e. fill in medicare's deductible and coinsurance).

Currently, ADEA applies only to persons between the ages of 40 and 70.

Explanation of provision.—(a) The bill would extend the health insurance requirement of ADEA to persons over the age of 69, thereby removing the upper age limit, and makes corresponding changes in medicare law.

(b) ADEA would be amended to provide that the group health insurance requirement be exempted from the age limits.

(c) The bill would make other conforming amendments regarding special enrollment periods and the effective date of enrollment.

Effective date.—The effective date of paragraph (a) would apply to items or services furnished on or after January 1, 1986.

The effective date of paragraph (b) would be January 1, 1986.

The effective date of paragraph (c) would be January 1, 1986, with certain exceptions.

2. *Provisions relating from health maintenance organizations and competitive medical plans (sec. 132 of the bill)*

(a) Financial responsibility for patients hospitalized on the effective date of an enrollment or disenrollment.

Present law.—Under current law it is unclear who is responsible for payment when a medicare beneficiary is an inpatient of a hospital under the prospective payment system on the effective date of his/her TEFRA HMO/CMP enrollment. A similar problem exists for disenrollment. A TEFRA HMO/CMP is a health maintenance organization or competitive medical plan with a risk contract under Section 1876 of the Social Security Act, authorized under the Tax Equity and Fiscal Responsibility Act of 1982.

Explanation of provision.—Enrollment—a TEFRA HMO/CMP is not financially responsible for reimbursing covered inpatient stays in a PPS hospital for inpatient stays beginning before the effective date of the beneficiary's enrollment in the TEFRA HMO/CMP. Medicare will reimburse for the inpatient stay, if otherwise covered, as if the beneficiary were not enrolled in a TEFRA HMO/CMP. The TEFRA HMO/CMP will be responsible for any other services covered under medicare (i.e., all services except the inpatient stay, such as physician services provided to the patient during the inpatient stay) and any additional or supplemental services which would otherwise be due an enrollee, effective with the date of his/her enrollment in the TEFRA HMO/CMP. Medicare will make its normal monthly capitation payment to the TEFRA HMO/CMP beginning with the effective date of the enrollment, in addition to reimbursing for the inpatient stay. The enrollee is responsible for premium or other payments due to the TEFRA HMO/CMP effective with the effective date of enrollment.

Disenrollment—if the enrollee is an inpatient in a PPS hospital on the effective date of his/her disenrollment from the TEFRA HMO/CMP, the TEFRA HMO/CMP will be responsible for reimbursing for the full inpatient stay. Medicare will not make a monthly capitation payment nor will it pay for the inpatient stay under the regular medicare program after the effective date of enrollment. The TEFRA HMO/CMP is not responsible for any other covered medicare services, or any additional or supplemental services to the enrollee, beginning on the effective date of disenrollment. This provision would apply only if the enrollee is an inpatient of a PPS hospital provided for or arranged by the TEFRA

HMO/CMP, or if the services were emergency or urgently needed services. The enrollee is not responsible for any premium or other payments to the TEFRA HMO/CMP effective with the month of disenrollment.

Effective date.—The provision is effective for enrollments and disenrollments effective on or after October 1, 1985.

(b) Disenrollment procedures.

Present law.—Present law specifies the effective date disenrollment from a TEFRA HMO/CMP to be the first calendar month following a full calendar month after the request is made for termination.

Explanation of provisions.—Disenrollments would be effective with the first day of the first month following the month in which the disenrollment request was made. The provision would require that the beneficiary receive a copy of the disenrollment form and that materials be provided to the beneficiary explaining how long he/she must continue to use the HMO/CMP facilities in order to have the services covered.

The Committee is concerned that medicare enrollees should be able to disenroll from TEFRA HMO/CMP without experiencing long delays. The current law provisions could result in a delay of up to 60 days between the time the beneficiary requests disenrollment and the effective date of disenrollment. As a result of new computer systems the Health Care Financing Administration can now facilitate faster disenrollment. This provision would ensure that a medicare enrollee would never have to wait more than 30 days before the disenrollment request was effective.

In addition, the Committee is concerned that medicare beneficiaries may believe that filing a request to disenroll means they can immediately use the regular fee-for-service medicare program. This is not the case and the Committee is requiring that information be provided to beneficiaries clearly delineating when they may begin to use the regular medicare benefit.

Effective date.—The provision is effective for requests for termination of enrolment submitted on or after October 1, 1985.

(c) Review of marketing material.

Present law.—There are no present law provisions relating to marketing materials.

Explanation of provision.—The bill would require all TEFRA HMO/CMPs to submit all brochures, application forms, and promotional and informal material to the Health Care Financing Administration (HCFA) for approval, at least 45 days before issuance. HCFA would be required to review all these materials. If the HMO did not hear from the HCFA within the 45-day period, the organization could assume approval.

The Committee is concerned that there have been problems with the HMO demonstrations and with some of the ongoing TEFRA HMO/CMPs regarding their marketing materials. Some marketing materials have been misleading, or have not provided complete information to the medicare beneficiaries.

In the proposed regulations implementing the TEFRA HMO/CMP legislation the Secretary would have required review of marketing materials by HCFA for accuracy and completeness. These provisions were dropped when the final regulations were published.

The Committee is concerned that in several instances marketing material supplied to medicare beneficiaries has been misleading, inaccurate and, in some cases, has provided "incentives" to join, which are prohibited by statute. Considering that the TEFRA HMO/CMP benefit is a new benefit and a substantial departure from the traditional method of obtaining services under the medicare program, the Committee feels that a stringent review of marketing materials should be undertaken to ensure accurate description of both the benefit package available to TEFRA HMO/CMP beneficiaries and the limitations, if any, on the providers whose services they can use as enrollees. The Committee wishes to stress that the marketing material should explain the issue of the "lock-in" in full to beneficiaries prior to their signing up with the HMO/CMP, so that they are well-informed of the limitations on the providers from whom they may seek services.

The Committee understands that this will create an added burden on the central office of HCFA, but believes that this effort is necessary, at least for the early years of implementation of this benefit, in order to protect the interests of the medicare beneficiaries for whom this program designed.

Effective date.—The provision would apply to material for distribution on or after November 15, 1985. This provision would not apply to material which has been distributed prior to November 15, 1985.

(d) Prompt publication of the AAPCC.

Present law.—In order to establish the payment amounts to TEFRA HMO/CMPs the Secretary has developed a measure, called the Average Adjusted Per Capita Cost (AAPCC). There are no current law requirements relating to the specific date of publication of the AAPCC.

Explanation of provision.—The provision would require the Secretary to publish the AAPCC no later than September 7 of each year. The Committee believes that the Secretary has been slow in publishing the AAPCC. The Committee believes that both HMO/CMPs and HCFA should have as much time as possible to develop their adjusted community rate and to determine their benefit packages. In order to facilitate this, the Committee is requiring that the AAPCC be published six days after the final promulgation of the prospective payment regulations, required by law to be published September 1.

Effective date.—The provision would apply to determinations of per capita rates of payment for 1987 and subsequent years.

3. *Evaluation of preadmission and pre-procedure certification programs (sec. 133 of the bill)*

Present law.—Peer review organizations (PROs), with general responsibility to review quality and utilization for inpatient hospital services, have been directed specifically to reduce the rate of inappropriate admissions. All PROs do preadmission screening on some elective surgery. Four PROs are currently responsible for 100% preadmission review of non-emergency surgery.

PROs currently do not have authority to review outpatient care.

Explanation of provision.—The Secretary of HHS would be required to evaluate the efficacy of PRO programs with 100% pread-

mission elective surgery review compared with programs that include less comprehensive review.

The Secretary would be required to evaluate the feasibility of extending to PRO pre-procedure certification activities to outpatient and ambulatory settings. The Secretary would also be required to consider whether other organizations, including medicare carriers could more effectively conduct such pre-procedure screening.

Effective date.—A report to Congress would be due by December 31, 1986.

4. *Prohibition of administrative merger of renal disease networks with other organizations (sec. 134 of the bill)*

Present law.—The Secretary is required by statute to establish networks to assure the effective and efficient administration of the end stage renal disease (ESRD) program under medicare. The network organizations are responsible for performing functions which include: (1) encouraging the use of treatment settings most compatible with the successful rehabilitation of the patient; (2) developing criteria and standards relating to the quality and appropriateness of patient care; and network goals with respect to the placement of patients in self-care settings and undergoing or preparing for transplantation; and (3) evaluating the procedure by which facilities and providers in the network assess the appropriateness of patients for proposed treatment modalities.

Explanation of provision.—The bill would prohibit the Secretary from dismantling ESRD networks, or from consolidating their organizations and functions with Peer Review Organizations or any other entity without express statutory authorization.

Effective date.—The provision would be effective on enactment.

5. *Extension of certain medicare HMO demonstration projects (sec. 135 of the bill)*

Present law.—Present law permits waiver of certain medicare requirements when the Health Care Financing Administration enters demonstrations under its general demonstrating authority.

Explanation of provisions.—The Secretary would be required to extend for three additional years, the three municipal health services demonstration projects (Milwaukee, San Jose and Cincinnati) currently authorized under medicare demonstration authority. These demonstrations were authorized under authority provided in the Social Security Amendments of 1967 and 1972.

These demonstrations are explicitly designed to increase the access to medical care of underserved low-income medicare and medicaid beneficiaries. As currently structured these HMOs would fail to meet the enrollment mix criteria of the TEFRA HMO/CMP provisions. The Committee has decided to extend these demonstrations for three more years in order to provide them with the opportunity to meet the enrollment mix and other criteria required in order to qualify as TEFRA HMO/CMPs at the end of this three-year extension period. The Committee understands that these projects are moving toward a capitated basis of payment and the Committee action does not preclude the Secretary from moving toward a capitated payment method. The Committee expects these HMOs to begin enrolling private enrollees at the earliest opportu-

nity. The Committee directs the Secretary to continue to monitor these projects to assure that there is no deterioration in the quality of care provided by the projects.

Effective date.—Effective upon the date of enactment.

6. Technical Corrections (sec. 136 of the bill)

Present law.—Current medicare law contains a number of technical errors.

Explanation of provision.—(a) The bill would correct problems with the medicare special enrollment period and the premium penalty forgiveness for the working aged. The bill would correct an anomaly under which certain individuals who are working and covered by an employer group health plan receive only one special enrollment period and others receive more than one.

(b) In addition, it would make it clear that an individual would be eligible for forgiveness of the medicare premium penalty for any period during which he or she was over 65 and covered by an employer group health plan.

The provision requiring a person to meet the eligibility requirements of part A and to have filed for part A would be repealed.

(c) The bill would make certain corrections in spelling, language and indentation.

Effective date.—The changes made by paragraph (a) would apply to the first month that begins more than 90 days after the date of enactment with certain exceptions.

The changes made by paragraph (b) would apply to months beginning January 1983 for premiums for months beginning with the first month that begins more than 30 days after the date of enactment.

The changes made by paragraph (c) would generally be effective as though they had been included in the public laws that they correct.

C. CHANGES RELATING PRIMARILY TO PART B OF THE MEDICARE PROGRAM

1. Extension of physician fee freeze for nonparticipating physicians and improvements in the participating physician program (sec. 141 of the bill)

Present law.—Medicare pays for physician services on the basis of medicare-determined “reasonable charges”. Reasonable charges are the lesser of: (1) a physician’s bill charge; (2) the charge customarily made by an individual physician; or (3) the prevailing charge limit, derived from a statistical analysis of charges made by all physicians for services in a geographic area. The customary and prevailing charge screens are generally updated annually, on October 1. Increases in the prevailing charge levels are limited by an economic index that reflects general inflation and changes in physicians’ office practice costs.

Under the Deficit Reduction Act of 1984 (P.L. 98-369) the medicare customary and prevailing charges for all physicians’ services provided during the 15-month period beginning July 1, 1984 are frozen at the levels that applied for the 12-month period ending June 30, 1984. The actual charges of nonparticipating physicians

are also frozen during the 15-month period, at the levels they charged during April-June 1984.

The Deficit Reduction Act also instituted a medicare participating physician and supplier program. Participating physicians and suppliers voluntarily agree to accept assignment on all medicare claims for the 12-month period beginning on October 1 of a year. Nonparticipating physicians and suppliers can decide on a claim-by-claim basis whether or not to accept assignment.

The carriers responsible for paying medicare claims are required to monitor nonparticipating physicians' actual charges during the 15-month freeze. Physicians who knowingly and willfully bill beneficiaries in excess of what they charged during April-June 1984 can be subject to civil monetary penalties and/or exclusion from participation in medicare.

Explanation of provision.—Beneficiaries who receive services from participating physicians and suppliers know in advance of receiving services that all the services provided to them will be taken on an assigned basis, and that they will not incur out-of-pocket costs, outside of deductible and coinsurance amounts mandated by statute.

In order to encourage participation, the bill would establish direct financial incentives to physicians to participate. On October 1, 1985, any physician who enters into a participation agreement effective for the year beginning October 1, 1985, or who extends an existing agreement, would receive an update in customary and prevailing charges. The same prevailing charge screens would apply to all participating physicians, regardless of their participation status in the previous year. This is intended to provide an incentive for physicians to participate, and reflects the priority the Committee attaches to increasing participation rates.

With regard to customary charge updates, physicians who are participating for a second year may realize some advantage over physicians who are signing agreements for the first time. The updated customary charges of physicians who continue to participate would reflect their (unfrozen) actual charges made from April 1984 through March 1985. The updated customary charges of new participants would be based on their actual charges from the same period, but these physicians' actual charges were frozen at April-June 1984 levels.

The prevailing charge limits on which reasonable charge determinations for participating physicians would be based would reflect the updated customary charges of all physicians. Customary charges of nonparticipating physicians would be calculated (based on actual charges made from April 1984 through March 1985, although they were frozen at April-June 1984 levels) but these customary charges would be used solely for the purpose of computing updated prevailing charges for participating physicians; they would not be used to determine payment for nonparticipating physicians.

For any physician who is not covered by a participation agreement effective for the year beginning October 1, 1985, the current 15-month freeze on customary and prevailing charges would be extended for 12 months, beginning October 1, 1985.

The current freeze on the actual charges of nonparticipating physicians would also be extended for 12 months. This freeze at April-

June 1984 levels would apply to all physicians who are not participating physicians for the year beginning October 1, 1985, and is intended to protect beneficiaries from increased financial liability for the period during which medicare payments to nonparticipating physicians are frozen. For a physician who are participating in FY 1985 but drops out of the participation program in FY 1986 the freeze on medicare payments would apply, and, in addition, the newly nonparticipating physician would have his actual charges rolled back to the level charged in the period April/June 1984. The monitoring of nonparticipating physicians' actual charges would be continued through FY 1986.

On October 1, 1986, any physician who is covered by a participation agreement effective for the year beginning October 1, 1986 would receive customary and prevailing charge updates. Nonparticipating physicians for the year beginning October 1, 1986 would receive customary and prevailing charge updates. However, they would be subject to the prevailing charge limits that applied to participating physicians during the year beginning October 1, 1985 (the preceding fee screen year).

The continued application of this differential in prevailing charge screens would apply in future years. Thus a permanent differential would be established between the prevailing charges to which participating and nonparticipating physicians are subject to the prevailing charges applied to participating physicians in the previous year.

In response to complaints by participating physicians regarding billing and claims processing problems they encountered during the first year of the participating program, the bill would provide for the development of professional relations staff at the carriers dedicated exclusively to addressing the billing and other problems of participating physicians and suppliers.

The Committee intends that the Secretary devote sufficient funds to the carriers for maintenance of their toll-free telephone lines so that they are useful to beneficiaries seeking information about participating physicians and suppliers. Sufficient resources should also be devoted to ensure that participating physicians and suppliers enjoy the benefit of the carriers' direct lines for the electronic receipt of claims.

The bill eliminates the statutory requirement in the Deficit Reduction Act for publication of the Physician Assignment Rate List (PARL), which lists the name, address, specialty and previous year's assignment rate for all physicians and suppliers, irrespective of their participation status. The PARL is said to be confusing to beneficiaries and little used.

The Committee intends that the directories of participating physicians and suppliers be organized so as to be meaningful and useful to beneficiaries. For example, if, in especially large metropolitan areas, local medical markets can be identified, these should serve as the basis for organizing the directories.

The bill would require that the appropriate area directories be sent to all participating physicians in an area to facilitate and encourage the development of referral networks among participating physicians and suppliers. The Committee also expects that copies of the appropriate area directories of participating physicians and

suppliers be sent to the local and national offices of each Member of Congress to facilitate responses to beneficiaries' inquiries for information on the participating physicians and suppliers in their area.

The bill includes a provision which would require that, for all unassigned claims, the Explanation of Medicare Benefits (EOMB), provided to all medicare beneficiaries include a message reminding beneficiaries of the participating physician and supplier program, and providing them with the toll-free number for information in their area. The message would also remind beneficiaries of the limitation on the charges participating physicians and suppliers may impose; that is, that they cannot charge beneficiaries extra-billing amounts. The bill specifies that this provision be implemented by April 1, 1986. This gives the Secretary ample time to pilot-test messages, if necessary, to insure that they convey information to beneficiaries in a meaningful and appropriate fashion.

The provision in the Deficit Reduction Act for the transfer in fiscal year 1985 of \$15 million from the Federal Supplementary Medical Insurance trust fund to the carriers would be extended to apply to fiscal year 1986 (in the same amount), for the continued administration of the physician fee freeze and participating physician and supplier program.

Effective date.—The fee freeze and participating physicians provisions would apply to services furnished on or after October 1, 1985.

2. Expansion of membership and duties of the Prospective Payment Assessment Commission to include review of payments for physicians' services (sec. 142 of the bill)

Present law.—There currently exists no advisory body whose purpose it is to make recommendations regarding medicare physician payment.

Explanation of provision.—The Director of the Congressional Office of Technology Assessment would expand the membership of the Prospective Payment Assessment Commission to total 23 by appointing, not later than January 1, 1986, eight additional members to the Commission.

The Committee intends that two of the eight new appointments be reserved for representatives of rural hospitals and the nursing profession. The Committee also intends that rural physicians be represented by one of the six remaining new members.

The Chairman of the Commission would provide for two subcommittees of the Commission, one whose functions and responsibilities relate primarily to hospital payment issues and the other whose functions and responsibilities relate primarily to physician payment issues. The Committee anticipate that the Commission would act principally through these subcommittees; that is, the subcommittee with jurisdiction over a particular issue would be assigned to study it, and recommendations would emanate from that subcommittee. The Committee expects that the Commission would act as a whole only on occasions when the subcommittees' jurisdiction is overlapping.

The Chairman would have the discretion to assign members of the Commission to serve on either or both subcommittees, but

would initially assign to serve on the hospital payment subcommittee of the Commission all of the current members of the commission and the two newly appointed rural hospital and nurse representatives. The Chairman would initially assign to the physician payment subcommittee of the Commission the six remaining new members. The Commission would also employ as many as ten additional staff members (beyond the existing limit of 25 plus an executive director), and would have the discretion to assign staff to either or both subcommittees as appropriate, in light of the workload and particular skill requirement of the respective subcommittees.

The mission and duties of the physician payment subcommittee would be to make recommendations to the Congress by February 1 of each year (beginning with 1987), regarding adjustments to the reasonable charge levels for physicians' services, and changes in the methodology for determining and making payment for medicare physicians' services and other items and services under part B.

In making its recommendations, the physician payment subcommittee would consider and develop options concerning reduction of existing specialty and geographic differentials in the payment amounts for physicians' services under part B, and would review the input costs associated with the provision of different physicians' services. The subcommittee would identify reasonable charges that seem out-of-line.

The subcommittee would assess the likely impact of adjustments in payment rates on utilization, on physician participation in the participation program, and on beneficiary access to physicians' services. The subcommittee would also make recommendations on ways to increase participation and assignment rates.

The physician payment subcommittee would identify procedures for which payments for assistants-at-surgery should be eliminated; and procedures for which second opinions should be required.

The bill would require the subcommittee to develop recommendations on the advisability and feasibility of making changes in the medicare physician payment mechanism, based on the HHS study of physician DRGs and the OTA study of fee schedules.

The subcommittee would also advise the Secretary on the development of a relative value scale (RVS). The Committee expects that the physician payment subcommittee in making its recommendations, and the Secretary in developing an RVS, will consider such factors as the input costs of furnishing particular physicians' services, and existing charge levels. Analysis of the input costs of all physicians' services would not be required, but the committee expects that services and items which are high volume among the medicare population, or which account for a long share of medicare physician spending, or for which the charges seem "out-of-line" would be examined. Services that can appropriately be "bundled," and for which medicare payment could be made on the basis of a global or comprehensive fee would also be identified and considered in developing the RVS.

In developing the RVS, the Secretary would be directed to consider the OTA study of fee schedules and the subcommittee's recommendations. The Secretary would be required to report to Con-

gress on the development of the RVS not later than April 1, 1987 for implementation October 1, 1987. The committee expects that the report would include an analysis of the likely impact of the RVS on participation and assignment, access to care and utilization.

Effective date.—The provision would be effective October 1, 1985.

3. *Part B premium (sec. 143 of the bill)*

Present law.—The Secretary is required to calculate and announce each September the amount of the monthly premium that will be charged in the following calendar year for people enrolled in the Supplementary Medical Insurance (part B) portion of medicare. A temporary provision of law requires that for 1986 and 1987 the premium amount be calculated so as to produce premium income equal to 25 percent of program costs for enrollees age 65 and over.

Beginning in 1988, the premium calculation would revert to an earlier method under which the premium amount is the lower of: (1) an amount sufficient to cover one-half of program costs for the aged; or (2) the current premium amount increased by the percentage by which cash benefits were most recently increased under the cost-of-living adjustment (COLA) provisions of the Social Security program.

Explanation of provision.—The bill would extend for one additional year the existing temporary provision whereby the portion of part B costs financed by enrollee premiums equals 25 percent of program costs. If there is Social Security cost-of-living adjustment, the monthly premium would not be increased for that year.

Effective date.—The provision would be effective on enactment.

4. *Determinations of inherent reasonableness of charges and charges and customary charges for certain former hospital-compensated physicians (sec. 144 of the bill)*

Present law.—(a) Inherent reasonableness—Payment for items and services under part B is generally made on the basis of reasonable charges. The reasonable charge is defined as the lowest of the actual charge, the customary charge and the prevailing charge for a given item or service. An economic index limits increases in prevailing charges for physicians' services. The law provides for some flexibility in the determination of reasonable charges, and regulations specify criteria that may be used in making these determinations. The regulations at 42 CFR 405.502(a)(7) allow the use of "other factors that may be found necessary and appropriate with respect to a specific item or service . . . in judging whether the charge is inherently reasonable."

(b) Hospital-compensated physicians—With the elimination of combined-billing arrangements, effective October 1, 1983, carriers established compensation-related customary charges (CRCCs) for certain hospital-based physicians. The CRCC provision was intended to be transitional; hospital-based physicians would have received customary charge updates on July 1, 1984 based on their actual charges had it not been for the freeze on medicare customary and prevailing charges for physicians' services instituted by the Deficit Reduction Act.

Explanation of provision.—(a) Inherent reasonableness—The provision would require the Secretary to publish regulations which (1) specify the factors to be used in determining the cases (of particular items and services) for which the applications of the reasonable charge methodology results in reasonable charges that, by reason of their grossly excessive or grossly deficient amounts, are not inherently reasonable, and (2) specify, in such cases, the factors that will be considered in establishing reasonable charges that are realistic and equitable. The requirement for promulgation of such regulations is intended to prevent arbitrary application of inherent reasonableness and to expose to public comment the process and criteria to be used.

In indentifying the kinds of cases in which to apply inherent reasonableness criteria, the Secretary should consider situations such as those in which charges (1) are substantially in excess of acquisition or production costs; (2) reflect a market dominated by one or few providers or suppliers; (3) do not reflect changes in technology; (4) are substantially higher to medicare patients than to others; or (5) reflect unrealistically low payment amounts, such as those that resulted from the application of the CRCC methodology for hospital-based physicians.

In establishing a reasonable charge that is realistic and equitable, the Secretary could specify that such factors as charges in other localities and manufacturers' wholesale price lists or suggested retail prices be considered.

This provision is to provide for adjustments in cases in which the charges determined by the reasonable charge methodology are not inherently reasonable. The Committee does not intend that this provision be used as a means to alter the basic methodology for determining reasonable charges, or to challenge such practices as recognizing speciality and geographic differentials in payment.

(b) Hospital-compensated physicians—Hospital-based physicians (HBPs) who, between October 31, 1982 and January 31, 1985, were in (and within the same time period terminated) arrangements by which they were compensated by a hospital for part B services furnished to its patients, would receive customary charges based on their actual charges.

On October 1, 1985, participating physicians who are covered by this provision would have their customary charges updated based on actual charges made during the 12-month period ending March 31, 1985. This is the same base period used to update the customary charges of other participating physicians. Nonparticipating physicians covered by this provision would have their customary charges updated on October 1, 1985 based on actual charges serving the same base period, but their customary charges would be deflated to approximate levels based on 1982 actual charges, on which other nonparticipating physicians' customary charges would be based under the bill.

The bill specifies that the customary charges of the nonparticipating physicians would be deflated by multiplying them by .83. This factor was determined by taking the ratio of the physicians' services component of the CPI (all urban consumers, seasonally-adjusted) for September 1984 and June 1982, the midpoints of the

base periods of the October 1, 1985 and July 1, 1984 fee screen updates, respectively.

On October 1, 1986, participating and nonparticipating physicians covered by this provision would be treated the same as all other participating and nonparticipating physicians.

Effective date.—The provisions relating to inherent reasonableness are effective upon enactment and the provisions with respect to hospital-compensated physicians would be applicable with respect to services furnished on or after October 1, 1985.

5. Occupational therapy services (sec. 145 of the bill)

Present law.—Occupational therapy is a medically prescribed treatment concerned with improving or restoring functions that have been impaired by illness or injury or, when functions have been permanently lost or reduced by illness or injury, with improving the individual's ability to perform those tasks required for independent functioning.

Medically necessary occupational therapy services are covered under part A of medicare when provided as a part of covered inpatient or post-hospital extended care services in a skilled nursing facility, or as part of home health services or hospice care.

Part B coverage is limited to treatment in a hospital outpatient department, comprehensive outpatient rehabilitation facility, home health agency or when incident to a physician's service.

Explanation of provision.—The bill would extend reimbursement under part B of medicare for occupational services. Occupational therapy would be covered when provided in a skilled nursing facility (when part A coverage is exhausted), in a clinic, or a rehabilitation agency. Payment would be made on a reasonable cost basis.

In addition, occupational therapy services furnished in a therapist's office or a beneficiary's home would be covered. The independently practicing therapist would be required to meet licensing and other standards prescribed by the Secretary. No more than \$500 in incurred expenses would be eligible for coverage in a calendar year per beneficiary. Payment would be based on 80% of reasonable charges.

Generally speaking, the bill would make medicare coverage of occupational therapy services comparable to the existing coverage of physical therapy services.

The Committee believes that the value of occupational therapy services to beneficiaries merits a modest expansion of the program. Further, the Committee finds that such services have the potential to reduce and avoid the need for institutional care while enabling the beneficiary to function more independently.

Effective date.—The bill would be effective for items or services furnished on or after October 1, 1985.

6. Payment for durable medical equipment (sec. 146 of the bill)

Present law.—Durable medical equipment (DME) is a covered part B benefit reimbursable on the basis of reasonable charges. In the past, medicare payment for DME was made for both rented and purchased items, depending on the beneficiary's decision to either rent or purchase. As a result, the majority of DME was rented, even when purchase would have been more economical.

Beginning February 1, 1985, the Secretary implemented three methods for reimbursing DME under medicare: lease-purchase, lump sum purchase or rental charges. Equipment costing less than \$120 is considered inexpensive equipment and payment is made only on the basis of purchase. For equipment costing more than \$120, the carrier must determine which method is cost-effective based on the beneficiary's expected need for the equipment (as indicated on the physician's prescription) and reimburse accordingly. Used equipment that is purchased and that meets certain standards is reimbursed at 100% rather than 80% of the reasonable charge (applicable copayment amounts are waived).

The beneficiary still has the option to rent or purchase DME. However, payment is made pursuant to the carrier's determination as to which method is cost-effective.

The prevailing and customary amounts for DME (both rental and purchase) are updated annually on July 1 (October 1, beginning with 1985). The amount by which the prevailing and customary charges increase is not limited by any economic index.

It has been recognized that the prevailing and customary charge amounts for DME reimbursed on a purchase basis are not well established in certain areas. As a result, the Secretary has instructed the carriers to use other methods when there are insufficient actual charge data for determining the customary or the prevailing charge in the locality.

Suppliers are able to sign participating agreements with the Secretary whereby they agree to accept assignment for all medicare claims for a year. Nonparticipating suppliers can choose on a claim by claim basis whether or not to accept assignment.

Explanation of provision.—(a) The bill would set new reimbursement limits on rented durable medical equipment. In determining medicare's customary and prevailing charges for rented DME during FY 1986, the Secretary would allow an increase of no more than one percent over the level set for rented equipment furnished beginning July 1, 1984.

(b) Medicare payment for durable medical equipment provided on a rental basis would only be made on the basis of mandatory assignment, i.e., the supplier would be required to accept medicare's allowable charge as his or her full charge and could collect from the beneficiary no more than the applicable deductible and coinsurance.

(c) For DME items furnished on or after October 1, 1986, the bill would limit the increase in prevailing charges for rental and purchase to no more than the Consumer Price Index for all urban consumers.

The Committee intends that the Secretary, in applying the CPI index to the prevailing charges for purchased equipment for FY 1987, provide for an adjustment where it appears that the indexed charges for a particular item would result in significantly inappropriate amounts, in accordance with her authority under the bill's provisions relating to "inherent reasonableness" or charges.

Effective date.—Paragraph (a) would be effective with respect to items or supplies furnished on or after October 1, 1985.

Paragraph (b) would be effective with respect to items or supplies furnished on or after January 1, 1986.

Paragraph (c) would be effective with respect to items or supplies furnished on or after October 1, 1986.

7. Payment for assistants at surgery for certain cataract operations and other operations (sec. 147 of the bill)

Present law.—Currently, medicare covers assistants at surgery during routine cataract operations. Their services are considered reasonable and necessary if it is the generally accepted practice among ophthalmologists in the local community to use an assistant at surgery. Some medicare carriers restrict coverage of assistants at surgery to cases where medical necessity is established.

Explanation of provision.—The bill would deny medicare payment for assistants at surgery for routine cataract operations. In cases where complicating medical conditions exist, the Secretary would be required to establish procedures by which the primary surgeon could request prior approval from the PRO for the use of an assistant.

The assistant at surgery (or someone on his or her behalf) would be prohibited from billing medicare or the beneficiary for services which did not receive a prior approval. In addition, the primary surgeon (or someone on his or her behalf) would be prohibited from including charges for the assistant in his or her bill for services. The proposal would give the Secretary the authority to impose civil monetary penalties or assessments, or exclusion for up to five years from the medicare program, or both, in order to enforce this provision and to ensure that beneficiaries are protected from additional out-of-pocket costs.

The Committee reviewed the findings of the Office of the Inspector General, HHS, which stated that the use of an assistant at surgery was not medically necessary in most situations. This finding was based on the practices of many primary ophthalmic surgeons who do not use such assistants. In addition, several medicare carriers currently restrict coverage of assistants at surgery.

The Secretary would be required, after consultation with the Prospective Payment Assessment Commission as reconstituted under the bill, to develop and report to Congress by April 1, 1986, recommendations and guidelines regarding other surgical procedures for which an assistant at surgery generally is not medically necessary. The Secretary would be required to include in this report procedures by which the primary surgeon could request prior approval from an appropriate entity for the use of an assistant at surgery when prior approval is required for these other surgical procedures.

Effective date.—This provision would be effective with respect to services performed on or after October 1, 1985.

8. Limitation on medicare payment for post-cataract surgery patients (sec. 148 of the bill)

Present law.—Medicare part B pays for certain combinations of prosthetic lenses, if determined to be medically necessary by the physician, i.e., cataract contact lenses and eyeglasses. Generally, part B carriers are authorized to replace prosthetic lenses without a physician's order in cases of loss or irreparable damage and when supported by a physician's order in cases of a change in the pa-

tient's condition. Currently, there are no uniform limits on the number of replacements for which medicare will provide reimbursement.

Physicians can bill medicare for services related to cataract surgery in two ways: (1) a comprehensive service code covering the lenses, their fitting and evaluation, and short-term follow-up to assure their suitability; or (2) separate codes for the lenses and for the physician's services.

Explanation of provision.—With respect to replacement of lost or damaged prosthetic lenses, the bill would limit medicare reimbursement as follows:

- (1) cataract eyeglasses: one replacement each year;
- (2) cataract contact lenses; one original and two replacements per eye the first year after surgery and two replacements per eye each subsequent year. The Secretary will determine the "years" over which these limitations will apply and anticipates the possibility that calendar years will be used.

The Secretary would be required to provide for separate payment amount determinations for the prosthetic lenses and for the related professional services, and to apply inherent reasonableness guidelines, in accordance with a separate provision of the bill, in determining reasonableness of charges for prosthetic lenses.

The Committee accepted the recommendations of the General Accounting Office which suggested the need for uniform limits for the replacement of such lenses. The Committee believes that these limits will ensure that benefits are uniformly applied.

The Committee intends, however, that the Secretary would not apply these limits where replacement of such lenses is the result of either a change in the patient's condition (and is supported by a physician's order) or of the natural wearing out of a lens.

Effective date.—The bill would be effective for items or services furnished on or after October 1, 1985.

9. Demonstration of preventive health services under medicare (sec. 149 of the bill)

Present law.—Medicare does not generally provide coverage for preventive health services.

Explanation of provision.—The Secretary of HHS would be required to fund at least five demonstrations, under the auspices of schools of public health, to determine whether and how it would be cost-effective to include preventive services as a medicare benefit.

Services to be made available to beneficiaries would include health screenings, health risk appraisals, immunizations, counseling and instruction on such matters as diet and nutrition, reduction of stress, exercise, sleep regulation, prevention of alcohol and drug abuse and mental health disorders, self-care, and smoking reduction.

Within three years, the Secretary would be required to submit a report to Congress describing the demonstrations in progress. Within five years the Secretary would be required to submit a final report that would evaluate the costs and benefits of providing such services and recommend whether specific preventive services should be included as a medicare benefit.

Effective date.—The provision would be effective on October 1, 1985.

D. PRIVATE HEALTH INSURANCE CONTINUATION

1. Temporary extension of coverage at group rates for family members of deceased, divorced or medicare-ineligible workers (sec. 161 of the bill)

Present law.—Under current law, there are no Federal requirements that employer-based group health insurance plans provide continuation or conversion options for any individuals who lose coverage in the health plan under any circumstances.

Explanation of provision.—The Committee is concerned with reports of the growing number of Americans without any health insurance coverage and the decreasing willingness of our Nation's hospitals to provide care to those who cannot afford to pay. Since 1977, the number of Americans without any health insurance coverage has increased by 40%, from twenty-five million people to thirty-five million people, according to a study conducted by the Department of Health and Human Services. At the same time that the number of Americans without health insurance is climbing, the traditional commitment of our country's hospitals to provide charity care is eroding. According to the American Hospital Association, one in every seven community hospitals adopted explicit limits on charity care in 1982 and 1983 alone.

In an effort to provide continued access to affordable private health insurance for some of these individuals, the Committee has proposed the following legislation.

The bill would amend Section 162 of the Internal Revenue Code to deny the business tax deduction for a group health plan of any employer who fails to include in the plan a continuation option to (1) a widowed spouse and dependent children, (2) a divorced or separated spouse and dependent children, or (3) a medicare ineligible spouse and dependent children.

A five-year continuation option would be available to the above groups after which time they would be offered the right to convert to an individual policy. The option of electing continuation coverage would be offered during a period that begins when the individual otherwise would lose coverage under the group health plan (the termination date), lasts at least 60 days, and ends not earlier than 60 days after the date the individual is notified of his continuation coverage rights by the group plan or the termination date, whichever date is later.

The bill would allow a spouse or former spouse who has been a qualified beneficiary under the group plan to elect continuation coverage on his or her own behalf and on behalf of the qualified dependent children.

The coverage provided would not be conditioned on any physical examination or other evidence of insurability and would be identical in scope to the coverage provided under the group plan to similarly situated individuals in the group.

Coverage would be cancelled during the five-year period if the employer ceased to provide any group health plan to employees, the qualified beneficiary did not pay the premiums or became cov-

ered under another group policy or medicare, or if the qualified beneficiary remarried and became or could become covered under the new spouse's group health plan. The covered dependent child would lose coverage upon no longer meeting the plan's definition of a dependent child.

The qualified beneficiary would be required to pay both employer and employee shares of the premium costs, although the employer could assume the employer share if it wanted to. To prevent any gap in coverage, the qualified beneficiary who elects continuation coverage would be permitted to pay within 45 days of election of continuation coverage, for any premium owed for the preceding period—from the point of which coverage would otherwise have ended. The total premium charged by a group health plan for the continuation coverage would not exceed the sum of the employer and employee premiums generally charged to similarly situated beneficiaries. In order to protect the group plan from any increased costs due to the continuation of individuals under this bill, the total of all premiums charged by the plan in any plan year may be based upon reasonably anticipated community costs for such plan year of the entire pool of insured employees and other qualified beneficiaries under the plan, including persons receiving continuation coverage.

During the 180 days preceding the end of five years of continuation coverage, a qualified beneficiary would have the right to enroll under a conversion health plan, if such a conversion option is otherwise generally available to beneficiaries of the plan.

In accordance with regulations of the Secretary of the Treasury, the group health plan would provide written notice to each covered employee and spouse (if any), explaining the continuation and conversion options contained in the bill. The covered employee would be required to notify the group health plan administrator of any change in family status, i.e., separation, divorce or medicare eligibility, and the employer would be required to notify the group health plan administrator in case of the death of the covered employee, which would trigger eligibility for continuation coverage. Within 14 days after such notification, the administrator would be required to notify the affected qualified beneficiary of the date coverage would normally terminate and of the qualified beneficiary's right to elect continuation coverage and the election period during which the qualified beneficiary could exercise that right.

Effective date.—In general, the provision is effective for plan years beginning on or after January 1, 1986. In the case of a group health plan maintained pursuant to one or more collective bargaining agreements, the bill would not apply to plan years beginning before the earlier of the date on which the last of the collective bargaining agreements relating to the plan terminates or January 1, 1987.

MEDICARE HEARING AND APPEALS PROCESS

It has been thirteen years since this Committee has looked substantively at medicare's appeals procedure. Since that time the medicare program has undergone major changes. Inpatient hospital services that were reimbursed on a cost basis are now mostly

subject to the prospective payment system. An increasing amount of services once provided only on an inpatient basis are now being provided in ambulatory settings.

As a result of these changes the Committee believes that the current hearing and appeal procedure under medicare needs to be reviewed. The Committee wants to ensure that adequate procedural safeguards are provided to program beneficiaries, suppliers and providers.

The Committee will, therefore, hold hearings on this issue and, if warranted, take legislative action.

PHYSICAL THERAPISTS

Under current law, part B covers the services of a qualified physical therapist in independent practice when furnished by him or under his direct supervision in his office or in the patient's home. These services must be prescribed by a physician and furnished pursuant to a written plan of treatment established by a physician or a qualified physical therapist.

The Secretary is required, under present law, to establish conditions that an independently practicing physical therapist must meet in order to receive medicare reimbursement. The Secretary, by regulation, requires that a physical therapist in independent practice maintain an office or office space with the necessary equipment to provide an adequate program of physical therapy. This requirement is applied even to those therapists who operate exclusively in the beneficiary's home.

The Committee believes that the requirement that independently practicing physical therapists who operate exclusively in beneficiaries' homes maintain fully-equipped offices is unnecessary. The Committee therefore intends that the Secretary eliminate this regulatory requirement.

HOME HEALTH AGENCY SUPERVISION

The medicare law requires that a physician or registered nurse supervise patient care services provided by a home health agency. Some have urged that other health care professionals be permitted to perform this supervisory role.

The Committee believes it desirable for the Secretary to examine the question of whether other health care professionals, (e.g., physical therapists, occupational therapists, and speech-language pathologists) may be qualified to perform the supervisory role. The Committee expects the Secretary to report to Congress with recommendations on the appropriations and feasibility of allowing other health care providers to perform the supervisory role for a home health agency. The Committee intends that such report include recommendations on the appropriateness of allowing other health care professionals to supervise the administrative services provided by a home health agency. Further, the Secretary would be required to specify criteria and conditions for which they could fulfill the supervisory role.

The report would be due April 1, 1986.

In this regard, the Customs Service is urged to make best efforts to process incoming airline passengers subject to this fee structure in an expeditious manner. The Committee believes that a reasonable standard to strive for in processing all passengers on arriving flights is an average of 45 minutes.

Conforming amendments.—Section 252 of the bill contains several conforming amendments, including the repeal of section 424 of the Tariff Act of 1930 (19 U.S.C. 1524), which currently provides for receipts for reimbursable charges and expenses to be deposited as a reimbursement to Customs' appropriation instead of being covered into the Treasury as miscellaneous receipts.

Section 252 of H.R. 3034 would further amend section 305(i) of the Rail Passenger Service Act (45 U.S.C. 545(i)) to delete the provision exempting Amtrak for reimbursing the Federal Government for the cost of Customs or Immigration inspection. The change would be consistent with the purpose of the proposed bill, permitting Customs and Immigration to be reimbursed for the costs of services provided Amtrak.

Finally, section 53(e) of the Airport and Airway Development Act of 1970 (49 U.S.C. 1741(e)) is repealed to eliminate the distinction between overtime on Sundays and holidays and that on non-business hours on weekdays for commercial aircraft. However, as provided for in section 251(d), no overtime charges may be assessed for processing arriving airline passengers at any time during the 3-year life of the fee structure provided for in section 251.

Advisory Committee.—Section 253 of the bill provides for the establishment of an advisory committee to meet on a periodic basis and to advise the Secretary on issues relating to performance of Customs' services. The committee is to be made up of representatives from the airline, shipping and other transportation industries, the general public, and others who may be subject to the fees authorized by section 251. It is contemplated that the advice include, but not be limited to, such issues as the time periods during which such services should be performed, the proper number and deployment of inspection officers and the level of fees. The Secretary is directed to give substantial consideration to the views of this Committee in the exercise of his duties.

Effective period for fees.—Section 254 of the bill provides for a delayed effective date of 180 days from the date of enactment to give the Customs Service sufficient time to implement the new fee schedule. The fees provided for in this bill would remain in effect for a 3-year period beginning on that date.

TITLE III—AID TO FAMILIES WITH DEPENDENT CHILDREN AMENDMENTS

A. AFDC Quality Control

Present law.—The Federal government and the States have established ongoing quantity control systems. These systems have two goals: correcting faults in program administration that contribute to erroneous payments and reducing the extent of misspent benefit dollars. To these ends, they attempt to: (1) measure the extent and dollar value of errors in administration; (2) identify the

types and causes of errors; and (3) specify and monitor corrective actions taken to eliminate or reduce errors.

Fiscal sanctions have also been made a part of these systems. Under these sanctions, States can be held liable for the cost of benefit payments made in excess of Federally established error tolerance levels, often referred to as target error rates. Prior to enactment of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), HHS regulations required States to reach a 4 percent error tolerance level by fiscal year 1983. This policy was known as the Michel amendment and actually required States, between fiscal year 1981 and fiscal year 1983, to make progress toward the 4 percent standard in three equal installments.

P.L. 97-248 reduced the target error rate for AFDC to 3 percent for fiscal year 1984 and thereafter.

Explanation of provision.—The bill would modify the current error rate tolerance level for AFDC and would establish in statute the basic procedures that would be used to collect the error rate data, determine each State's error rate, and collect potential fiscal sanctions. The bill also specifies the basic terms and conditions for granting waivers of the fiscal sanctions. The specific provisions of the legislation are described below.

1. Establish minimum quality control policies and procedures in law.

States would be required to determine the AFDC error rate for each fiscal year in a manner similar to current practice. State could, at their option, collect either 2 six-month samples or an annual sample of their AFDC caseload to develop the error rate but would be prohibited from reducing their sample size.

The Federal re-review, analysis, and notice to the States of the official error rate would have to occur within six months after the close of the fiscal year for which the data are collected or six months from the date a completed State sample is submitted to the Federal regional office, whichever is later.

After completing the data collection process: (1) States would be required to develop and submit to the HHS Secretary a corrective action plan for reducing the indentified errors (including those not subject to fiscal penalties as discussed below); (2) the HHS Secretary would review and approve the plan, and; (3) States would be required to implement the corrective actions. The HHS Secretary would be required to establish a timetable for these activities in regulations and monitor the corrective action process. States with adjusted State error rates that are consistently at or below the adjusted State tolerance level (without excluding technical errors) would not be required to submit a corrective action plan for the Secretary's approval.

2. Set a new national standard for the AFDC error rate of 3.5 percent.

The standard tolerance level for overpayment errors would be permanently set a 3.5 percent. Under current law, States must reach a 4 percent standard tolerance level by fiscal year 1983; this declines to 3 percent for fiscal year 1984 and thereafter.

3. Determine the adjusted State error rate.

The procedures described in item 1 above would be used to obtain the raw error rate data. Subsequently, two adjustments would be made to produce the adjusted State error rate.

First, technical errors would be excluded for fiscal sanctions purposes. These are paperwork omissions which would not change the AFDC payment level. They include: failure to provide evidence in the case record of social security numbers, assignment of rights to support, cooperation in obtaining support, WIN registration, and other errors which have no fiscal impact.

Second, the point estimate of a State's error rate would be the lower bound of the range within which a State's true error rates falls, rather than the midpoint, if the State has a sample size sufficient to produce a lower limit of 2.5 percentage points or less than the midpoint. In the calculation of the lower confidence level, the Secretary would have the authority to promulgate regulations to adjust for variability among States in the number, proportion or dollar value of cases where the findings of the State quality control review differ from the Federal findings. These regulations would assure that States could not arbitrarily manipulate the original State findings to maximize the benefit of using the lower bound. It is expected that the regulations will establish an objective standard for the adjustment, most probably using a mathematical formula to be developed.

4. Recognize that certain factors beyond a State's control influence the error rate by adjusting the standard tolerance level annually for each State.

The current quality control system does not recognize error-relevant socioeconomic, geographic and program differences among the States which contribute to higher error rates and are not fully within the control of the States. Studies have shown that it is more difficult to make a correct determination of eligibility and payment amount in some cases than in others. For example, a case in which a member of the family is working, or has a recent work history, is more complicated than one in which there is no potential source of outside income. Similarly, an agency in a heavily populated area is likely to have a higher volume of cases which can contribute to the error rate.

To account for these factors, the standard tolerance level of 3.5 percent would be adjusted as follows:

(a) Add 0.5 percent to the standard level if the State has operated an AFDC unemployed parent program during the fiscal year.

(b) Add 0.1 percent to the standard level, up to a maximum of 0.5 percent, for each 20 percent increment by which the State exceeds the national average in terms of percent of total State AFDC caseload with earnings.

(c) Add 0.1 percent to the standard level, up to a maximum of 0.5 percent, for each 20 percent increment by which the State exceeds the national average in terms of population density (population per square mile of land area).

The steps described in item 3 produce the adjusted State error rate. The steps described in item 4 produce the adjusted State tolerance level.

5. Impose fiscal sanctions on the basis of the adjusted State error rate and the adjusted State tolerance level.

A State's fiscal sanction would be equal to the Federal portion of benefits paid above the adjusted State tolerance level using the adjusted State error rate.

A sanction amount would be reduced by the Federal share of overpayments collected by the State in the fiscal year to which the error rate applies.

The current authority for the HHS Secretary to waive sanctions to acknowledge certain circumstances would be retained and expanded. States could request a waiver based on the State's good faith effort to reduce errors. In making the waiver request, States would also be permitted to challenge the Federal error rate findings. The HHS Secretary would review and act on the request according to a timetable specified in regulations.

The regulations would also specify the criteria that would be used in assessing waiver requests and the relative importance of each factor so that States may informally assess whether a waiver request is appropriate. In reviewing the waiver request, the HHS Secretary would be required to consider the following:

(a) *Factors beyond the State's control*—such as disasters (fire, flood or civil disorders); strikes by State or other staff needed to determine eligibility or process changes in cases; sudden workload changes resulting from changes in Federal or State law and regulations or rapid caseload growth; and State actions which were the result of incorrect policy interpretations by a Federal official.

(b) *Factors related to agency commitment*—such as demonstrated commitment by top management to the error reduction program; sufficiency and quality of operational systems which are designed to reduce errors; use of effective systems and procedures for the statistical and program analysis of quality control and related data; and effective management and execution of the corrective action process.

(c) *Other factors as appropriate*—these may be identified by the Secretary in regulations or may be detailed by States in their waiver requests but would include past State error rate performance as well as the cost effectiveness of error reduction efforts.

States would be permitted to appeal the Secretary's decision on the waiver request described above to the HHS Grant Appeals Board and could also appeal to the courts.

In lieu of the waiver authority identified above, the Secretary would be required to permanently waive a sanction if the State submits a plan for the reduction of errors which includes the expenditure of additional State administrative funds equal to one-half of the sanction amount. These expenditures would be a Federally-matched administrative expense.

Effective date.—For FY 81 and 82, States would have the option of applying current law (the Michel amendment) or the new qual-

ity control system and standards. For FY 83 and thereafter, the new quality control system and standards would apply.

B. Teenage Pregnancy Block Grant

Present law.—Although some States are operating pilot service programs for teenage families, comprehensive prevention and service programs targeted to AFDC recipients do not exist in each State.

Explanation of provision.—

The bill authorizes a two-year grant program to permit the State AFDC agency to operate a two-part teenage pregnancy program.

Prevention program for AFDC families.—These activities would be targeted to male and female children in AFDC families and would include active parent participation; parental consent would not be required. The program would address several factors which have been shown to play important roles in determining teenage sexual activity and contraceptive use. These include low self-esteem and aspirations, ignorance about pregnancy and contraception, fear or embarrassment about contraceptive use, and concern about the effect of sexual abstinence or contraceptive use on the relationship.

Children would be encouraged to develop believable education and employment goals for the future and States would combine new and existing resources to assist them to achieve those goals. Such programs would encourage children to postpone sexual activity and child bearing in order to achieve these goals; taking responsibility for family planning would also be stressed.

Comprehensive service program for teenage AFDC parents.—Participation would be voluntary; male and female teenage parents who elect to participate would be required to seek a high school degree (or equivalent) and would receive services, including training, day care and transportation, to help them become self-sufficient and avoid long-term welfare dependence. States would be permitted to request a waiver to require participation in the program in jurisdictions with sufficient funding to serve all of those who would be eligible to participate.

These activities would be financed through a block grant to each State. The legislation authorizes the appropriation of \$50 million in fiscal year 1986 and \$100 million in fiscal year 1987. States would be entitled to receive a grant in each of the two fiscal years for which the program is authorized. Funds could only be used for the purposes specified above.

These funds could be used only for AFDC eligible individuals. However, it is expected that State prevention and service programs may also serve non-AFDC eligible individuals so long as these grant funds are not used to provide services to the non-AFDC population. In addition, in each locality within a State, both a prevention and a service program must be offered. However, it is not the intention of this legislation to duplicative in any way programs that may already be available within a jurisdiction. For this reason, States may use these funds to set up a prevention program, a service program or both, so long as prevention and service activities are available in each site receiving the block grant funds.

The appropriation would be allocated to the States on the basis of their percentage share of national AFDC benefit expenditures. States would be required to target the funds to areas of the State with a high rate of teenage pregnancy and/or a high incidence of infant mortality. Funds not used by any State would be reallocated on the basis of need to other States.

These block grants funds are in addition to AFDC funds provided to the States and are to supplement and not replace any funds that may be available for the same general purpose. Specifically, the funds may not be used to provide services which are available under the Medicaid program.

The legislation includes a prohibition on the use of block grant funds for the performance of abortions and for the counseling of individuals to have abortions except where the life of the mother would be endangered if the fetus were carried to term. This prohibition applies solely to the use of funds provided under the teenage pregnancy block grant established by section 302 of this bill, and is not intended in any way to alter current practices or law and regulations of other title IV or any other Social Security Act programs or other Federally funded health and public assistance programs.

The monies would flow to the State upon submission of a plan in accordance with regulations published by the Secretary of HHS. The plan would have to be approved by the Secretary; the monies could only be used for AFDC eligible individuals, and could not replace funds otherwise allocated for this purpose. A thorough evaluation would be required by July 1, 1987.

Effective date.—The teenage pregnancy prevention and services block grant would be in effect only from October 1, 1985 until September 30, 1987. However, funds allocated to States before September 30, 1987, could be carried over to the subsequent fiscal year as provided in the legislation.

C. AFDC For Unemployed Two-Parent Families

Present law.—It is a State option to aid needy two-parent families in which the principal earner is unemployed (i.e., the principal earner is working less than 100 hours per month and has six or more quarters of work in any 13-calendar quarter period ending within one year prior to applying for AFDC). Twenty-three States, Guam and the District of Columbia provide this assistance to needy intact families. In the States without a two-parent program, intact families cannot receive assistance or must separate in order to qualify for AFDC.

The States currently *without* a two-parent AFDC program are the following: Alabama, Alaska, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Kentucky, Louisiana, Maine, Mississippi, Montana, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wyoming.

Explanation of provision.—Effective October 1, 1986, the bill mandates that the current AFDC program for unemployed parents be implemented in all States. As a result, all States would aid needy two-parent families in which the principal earner is unemployed.

In addition, the definition of "quarters of work" would be modified to permit, at State option, the substitution of participation in school or training as follows: (1) school attendance would be limited to elementary or secondary school; (2) four quarters of vocational training could be substituted for four quarters of work; (3) attendance in school or vocational training would have to have been full-time; and (4) at least two of the six quarters must be quarters of work.

Effective date.—The provision would be effective on October 1, 1986.

TITLE IV—RAILROAD UNEMPLOYMENT REPAYMENT TAX AND UNEMPLOYMENT COMPENSATION AMENDMENTS

1. Railroad Unemployment Compensation

Present law.—The authority for the railroad unemployment compensation system to borrow from the railroad retirement account expires on September 30, 1985. On that date, the outstanding debt to the retirement account is estimated to be \$783 million, of which \$526 million is principal and \$257 million is accumulated interest.

There has been no automatic mechanism in the law to repay loans from the retirement account as they occur. Loans are repaid out of basic contributions to the unemployment account when the Railroad Retirement Board determines that there are sufficient funds in the unemployment account to make a repayment.

The Railroad Retirement Solvency Act of 1983 established a repayment tax that will begin on July 1, 1986 and will expire on September 30, 1990. The tax rate will begin at 2.0 percent and increase by 0.3 percent a year. The tax is paid on the first \$7,000 in wages paid to a rail employee.

Explanation of provision.—(1) The loan repayment tax, scheduled to begin on July 1, 1986 at a 2% rate with increases of .3% a year, is amended as follows:

Calendar Year	1986	1987	1988	1989	1990
Current law.....	2.0	2.3	2.6	2.9	3.2
Tax rate: Committee bill.....	4.3	4.7	6.0	2.9	3.2

(2) The RRUI Account's authority to borrow from the Railroad Retirement Account is extended, effective October 1, 1985.

(3) An automatic surcharge of 3.5% on an annual wage base of \$7,000 will be levied if the RUI Account has to borrow from the retirement account. The surcharge will be used to repay such loans.

Effective date.—The provision would be effective October 1, 1985.

2. Federal Supplemental Compensation

Present law.—The Federal Supplemental Compensation program (FSC), which provided additional weeks of unemployment compensation to individuals who had exhausted their regular State benefits, was due to expire on April 6, 1985. Public Law 99-15, enacted on April 4, 1985, allowed individuals who were receiving FSC benefits for the week of March 31–April 6, to continue to receive the

1985. The premium increase was made prospective because of the administrative burdens that would be imposed on plans if a retroactive increase were adopted and because the PBGC has indicated that this brief deferral will not jeopardize benefits under the program.

Because of present uncertainty as to the need for a structural revision of the program and the need to curtail abuses, the Committee agreed to limit the increased premium to a 3-year period. The Committee expects that, during this period, the PBGC and others will work with the relevant committees on recommendations with respect to benefits subject to insurance under the program, the means of financing of that insurance, and the need for additional measures to prevent abuse. Accordingly, under the Committee's bill, the annual single-employer plan per-participant premium returns to \$2.60 for plan years beginning after December 31, 1988.

Explanation of provision.—Under the bill, the annual per-participant premium for single-employer plans is increased to \$8.00, effective for plan years beginning after December 31, 1985, and before January 1, 1989. Under the bill, the premium for plan years beginning after December 31, 1988, is \$2.60. The bill does not modify the premiums for multiemployer plans.

Budget effect.—This provision is estimated to reduce fiscal year budget outlays by \$161 million in 1986, \$212 million in 1987, and reductions in budget outlays for budget purposes.)

III. OTHER MATTERS TO BE DISCUSSED UNDER HOUSE RULE

A. Vote of the Committee

In compliance with subdivision (B) of clause 2(1)(2) of rule XI of the Rules of the House of Representatives, the following statement is made relative to the vote of the Committee on the motion to report H.R. 3128:

H.R. 3128 was ordered favorably reported by a vote of 22 to 13.

B. Oversight Findings

In compliance with subdivision (A) of clause 2(1)(3) of rule XI of the Rules of the House of Representatives, the following statement is made with respect to the Committee's oversight findings:

The provisions of H.R. 3128 are consistent with the oversight findings of the Committee on Ways and Means and its subcommittees, as indicated by the information below and the explanations of the provisions in a previous section of this report.

Section 101 of the bill, which would provide for a rate of increase in payments for inpatient hospital services, is consistent with the General Accounting Office report on the use of unaudited cost reports. In its report the GAO determined that the use of unaudited 1981 cost reports by the Secretary in developing the PPS rates overstated the actual costs incurred by the hospitals in the base year by 4.39%. In addition, the Prospective Payment Commission (ProPAC), in its April 1, 1985 report to the Secretary of HHS, recommended an update of 2.8% for PPS hospitals. Furthermore, ProPAC recommended that PPS-exempt hospitals also receive an update for FY 1986.

Section 104 of the bill, which would change the formula for the indirect teaching adjustment, is consistent with the findings of the Congressional Budget Office. According to CBO the current linear method of calculating the adjustment factor may over compensate those hospitals with the highest interns to residents bed ratios. CBO suggested that an adjustment made on a variable basis would more accurately reflect the non-linear cost relationship. Futher, Pro PAC recommended that interns and residents assigned to the outpatient department be included in determining this adjustment. This recommendation was included in the provision.

Section 147 of the bill, which would change the payment policy for assistants at surgery for certain cataract operations and other operations, is based upon findings of the Office of the Inspector General of HHS in its OIG Audit Report (ACN 01-52001). The OIG, in its review of medicare payment for assistant surgeon services during cataract surgery, found that their services were not medically necessary in most situations. This finding was predicated on the practices of many primary ophthalmic surgeons who do not use them and the restrictive coverage policies of medicare carriers in nine states. The recommendations of the OIG were incorporated into this section.

Section 148 of the bill, which would place a limitation on medicare payment for cataract surgery patients, is based on findings by the General Accounting Office. In its report, 'Opportunities to Reduce Medicare Payments for Prosthetic Lenses While Enhancing Nationwide Uniformity of Benefits', (GAO/HRD 85-25), the GAO recommended that better controls be established regarding the replacement of prosthetic lenses (i.e. cataract contacts and eyeglasses) and the related professional services. The recommendations of GAO were included in this section.

In addition, the Subcommittee on Health took testimony from the Administrator of the Health Care Financing Administration, GAO, OIG, physician, hospital, supplier, beneficiary and other organizations. Several of their recommendations are included in H.R. 3128.

Section 302, which would provide grants for programs to assist pregnant individuals and teenage parents in achieving self-sufficiency, is based upon oversight hearings of the Subcommittee on Public Assistance and Unemployment Compensation. In these hearings, the Subcommittee learned that teenage mothers are frequently the children of teenage parents. Often they do not finish high school. They usually do not receive child support from the baby's father and over time they generally have more children than non-teenage mothers. Today, most teenage mothers do not marry the father of their child, but if they do, the marriage often ends in divorce. Most end up as single parents earning low wages, if they are able to find work at all.

Without an education or job skills, teenage mothers must frequently turn to aid to families with dependent children (AFDC) for meeting their needs. In fact, studies show that half of all AFDC expenditures go to households in which the mother had her first child as a teenager. Approximately 60 percent of all teenage mothers receive welfare at some time and among AFDC mothers under the age of 30, fully 61 percent were teenage mothers.

Section 303, which mandates aid to families with dependent children in two-parent families in all states, is based upon studies and hearings of the Subcommittees on Oversight and Public Assistance and Unemployment Compensation.

In May, the Congressional Research Service and the Congressional Budget Office reported the results of a study, requested by Subcommittees. The study found that there were 13.8 million poor children in 1983 and that the incidence of poverty among children climbed more than 50 percent from 1973 to 1983. Children are the poorest age group of the entire population. More than half the children in all female-headed families are poor while more than two-thirds of the children in black female-headed families are poor. In excess of 2.5 million children were poor in 1983 even though a parent worked full-time year round. Almost half of all black children and more than one-third of all hispanic children were poor in 1983.

Whether poverty is measured before or after government transfer payments (social insurance and welfare) and whether the income counted includes or excludes noncash benefits and money paid as taxes, child poverty rates rose especially sharply from 1979 to 1983.

Section 501, which restores funding for the Internal Revenue Service, is based upon hearing of the Subcommittee on Oversight.

C. Budget Effects

1. Committee Estimate

In compliance with clause 7(a) of Rule XIII of the Rules of the House of Representatives, the following statement is made relative to the budget impact of by H.R. 3128, as reported by the Committee. The Committee agrees with the cost estimates regarding the spending (outlay) provisions and revenue provisions prepared by the Congressional Budget Office. Some of the revenue provisions were estimated by the Joint Committee on Taxation and are included in the letter prepared by the Congressional Budget Office.

Table 1 below summarizes the budget effects of the spending and tax provisions of the Committee reported bill under the economic assumptions and baseline used in the House-passed fiscal year 1986 budget resolution. The table shows the revenue impact of the Appropriation's Committee (H.R. 3036) action with respect to increases in the number of staff positions in the Internal Revenue Service and the U.S. Customs Service. The estimates in the table reflect the Committee's intention that the number of staff positions in these two agencies not be decreased for fiscal years 1987 and 1988. Following normal budget scorekeeping conventions, the authorizations for these positions are not shown.

Table 2 shows the budget effect for each provision with the bill under the assumptions stated above. The budget effect includes all impacts the provision may have on other programs. For example, many of the Medicare and AFDC provisions have impacts upon the Medicaid program, premiums paid by Part B enrollees of the food stamp program. Simply stated, Table 2 shows the impact of each provision upon the budget deficit. For a more detailed breakout of

the different program effects from a given provision, see the CBO letter.

TABLE 1. SUMMARY OF COMMITTEE ON WAYS AND MEANS DEFICIT REDUCTION BILL (H.R. 3128)

[In millions of dollars]

	Fiscal year—			
	1986	1987	1988	3-year total
Recommendations from:				
Subcommittee on Health ¹	—\$2,237	—\$3,355	—\$4,679	—\$10,271
Subcommittee on Trade ¹	—225	—680	—855	—1,760
Subcommittee on Public Assistance and Unemployment Compensation ¹	54	163	214	431
Pension Benefit Guaranty Corporation proposal	—161	—212	—239	—612
Revenue proposals	—2,011	—2,438	—2,567	—7,016
Total deficit reduction achieved	—4,580	—6,522	—8,126	—19,228

¹ Also includes a revenue item.

Note.—These estimates are from either the CBO or Joint Committee on Taxation. A (—) sign indicates deficit reduction; a positive number indicates a budget deficit increase.

TABLE 2. OUTLAY AND REVENUE PROVISIONS REPORTED BY THE COMMITTEE ON WAYS AND MEANS RELATED TO THE REQUIREMENTS OF THE HOUSE-PASSED FISCAL YEAR 1986 BUDGET RESOLUTION

[In millions of dollars]

Section	Fiscal year—			
	1986	1987	1988	3-year total
Medicare:				
101 Limit hospital rate of increase	—\$1,375	—\$1,875	—\$2,120	—\$5,370
102 Transition to national rates	0	0	0	0
103 Hospital area wage index	(¹)	0	0	0
104 Indirect teaching adjustment	—320	—530	—800	—1,650
105 Disproportionate share adjustment	0	0	0	0
106 Rural osteopathic hospitals as rural referral centers	0	0	0	0
107 Direct medical education	0	0	0	0
108 Return on equity payments	—6	—112	—297	—415
109 Allow continued Medicare waivers for certain areas	0	0	0	0
110 Four-year test for State waivers	0	0	0	0
111 Special rule related to donated property	0	0	0	0
112 Report on outliers and transfer policy rural hospitals	0	0	0	0
113 Information on impact of PPS payments	0	0	0	0
121 Hospital extension	(¹)	(¹)	(¹)	(¹)
122 Limit the late enrollment penalty for Medicare part A	5	5	5	15
123 Cover newly hired State and local employees under Medicare (revenues)	—53	—191	—293	—537
124 Antidumping provision	0	0	0	0
131 Working Aged Expansion	—225	—344	—383	—952
132 HMO Technical Amendments	0	0	0	0
133 Evaluation of Preadmission Certification Programs	0	0	0	0
134 ESRD networks	0	0	0	0
135 Extension of Certain Medicare HMO demonstration projects	0	0	0	0
136 Technical corrections	0	0	0	0
141 Physician fee freeze extension	—195	—209	—269	—673
142 Physician payment arm of PROPAC	0	0	0	0
143 Part B premium	0	0	—387	—387
144 Reform fees for hospital-based physicians	0	0	0	0
145 Occupational therapy services	13	17	17	47
146 Payment for durable medical equipment	—30	—58	—89	—177
147 Assistant surgeons' fees for routine cataract operations	—22	—26	—26	—74
148 Limit Medicare payment for cataract surgery	—30	—33	—38	—101
149 Preventive services demonstrations	1	1	1	3

TABLE 2. OUTLAY AND REVENUE PROVISIONS REPORTED BY THE COMMITTEE ON WAYS AND MEANS RELATED TO THE REQUIREMENTS OF THE HOUSE-PASSED FISCAL YEAR 1986 BUDGET RESOLUTION—Continued

[In millions of dollars]

Section		Fiscal year—			
		1986	1987	1988	3-year total
161	Private health insurance continuation	0	0	0	0
	Total	-2,237	-3,355	-4,679	-10,271
201- 231	Trade Adjustment Assistance: Reauthorize Firm Program and Amend Worker Program ² ..	0	0	0	0
242	Customs Service: Reauthorize and improve operations of Custom Services (revenues)	-150	-450	-615	-1,215
251	User Fees	-75	-230	-240	-545
301	Aid to Families with Dependent Children: Quality control	4	4	62	70
302	Teenage Pregnancy Block Grant	50	100	0	150
303	AFDC for unemployed two-parent families	0	160	250	410
401	Railroad Unemployment Compensation: Increase in railroad unemployment repayment tax (re- venues)	0	-101	-98	-199
403	Supplemental unemployment compensation for certain individuals	(¹)	0	0	0
501	Revenues: Improvement in IRS operations	-228	-465	-580	-1,273
502	Cigarette tax made permanent ³	-1,536	-1,682	-1,686	-4,904
503	Increase in black lung coal excise taxes ³	-213	-229	-236	-678
504	Tax treatment of rail retirement benefits	-34	-62	-65	-161
	Revenue total	-2,011	-2,438	-2,567	-7,016
505	Pension Benefit Guaranty Corporation: Increase in premiums	-161	-212	-239	-612
	Total deficit reduction	-4,580	-6,522	-8,126	-19,228

¹ Less than \$500,000

² These provisions of the bill would most likely increase entitlement costs, but no data exist to permit estimating such costs. For a more complete explanation, see the following CBO letter.

³ Net increase in budget receipts (after income tax offset).

Note.—A (—) sign indicates deficit reduction; a positive number indicates a budget deficit increase.

2. Cost Estimate Prepared by the Congressional Budget Office

In compliance with 2(1)(3)(C) of rule XI of the Rules of the House, requiring a cost estimate prepared by the Congressional Budget Office, the following letter prepared by Congressional Budget Office is provided.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 31, 1985.

HON. DAN ROSTENKOWSKI,
Chairman, Committee on Ways and Means, U.S. House of Repre-
sentatives Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for H.R. 3128, the Deficit Reduction Amendments of 1985, as ordered reported by the House Committee on Ways and Means on July 31, 1985.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,
Sincerely,

RUDOLPH G. PENNER.

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: H.R. 3128.
2. Bill title: The Deficit Reduction Amendments of 1985.
3. Bill Status: As ordered reported by the House Committee on Ways and Means on July 31, 1985.
4. Bill purpose: To make changes in spending and revenue provisions for purposes of deficit reduction and program improvement consistent with the budget process.
5. Estimated cost to the Federal Government: Two federal cost tables are displayed below. The first table shows the costs or savings estimated relative to current law. This is consistent with the standard cost estimate format used by the Congressional Budget Office. Because this bill is intended as a reconciliation act, we have also included a second table displaying estimates relative to the House Budget Committee baseline. The baseline differs from current law primarily in that it assumes the reauthorization of certain programs.

FEDERAL COSTS RELATIVE TO CURRENT LAW

(In millions of dollars)

	By fiscal year—				
	1986	1987	1988	1989	1990
Budget authority	—\$345	—\$195	—\$347	\$327	\$879
Outlays	—2,296	—3,272	—4,483	—4,794	—5,204
Authorization levels	859	55	58	60	0
Outlays	755	137	70	72	9
Total budget authority/authorization level	514	—140	—289	387	879
Outlays	—1,541	—3,135	—4,413	—4,722	—5,195
Revenues	—1,986	—2,303	—2,378	—2,409	—2,561
Net change to the deficit (outlays less revenues)	—3,527	—5,438	—6,791	—7,131	—7,756

FEDERAL COSTS RELATIVE TO BASELINE

By fiscal year—

(In millions of dollars)

	By fiscal year—				
	1986	1987	1988	1989	1990
Budget authority	—\$415	—\$265	—\$417	\$257	\$879
Outlays	—2,366	—3,342	—4,553	—4,864	—5,204
Authorization levels	66	0	0	0	0
Outlays	58	6	1	1	0
Total budget Authority/authorization level	—349	—265	—417	257	879
Outlays	—2,308	—3,336	—4,552	—4,863	—5,204
Revenues	—1,986	—2,303	—2,378	—2,409	—2,561
Net change to the deficit (outlays less revenues)	—4,294	—5,639	—6,930	—7,272	—7,765

Basis of estimate: The section-by-section cost analysis deals with only those sections of the bill that are anticipated to have a budget impact. The first table provides a section-by-section analysis of the estimated revenue or outlay changes relative to the baseline from the enactment of this legislation. The second table displays estimated changes that would result from current law where current law differs from baseline.

COST ESTIMATES FOR WAYS AND MEANS CHANGES FROM BASELINE: CBO JULY 31, 1985

[Outlays, in millions of dollars, by fiscal year]

	1986	1987	1988	1989	1990	1986-88
TITLE I						
101 Limit Hospital Increase.....	-1,375	-1,875	-2,120	-2,370	-2,635	-5,370
103 Prohibit Retro. Wage Adjust.....	*	0	0	0	0	0
104 Reduce Indirect GME.....	-320	-530	-800	-1,050	-1,160	-1,650
107 Direct GME Freeze Prohibition.....	0	0	0	0	0	0
108 Reduce return on Equity.....	-6	-113	-298	-329	-369	-417
Medicaid.....	0	0	0	0	0	0
Premiums.....	0	1	1	1	1	2
Total.....	-6	-112	-297	-328	-368	-415
121 Hospice Ext. and Payment Incr.....	(¹)	(¹)	(¹)	(¹)	(¹)	(¹)
122 Reduce Penalties for Delay.....	5	5	5	5	5	15
123 Medicare Coverage for New State and Local Employees (Revenue).....	-53	-191	-293	-394	-537	-537
131 Working Aged.....	-230	-360	-400	-460	-520	-990
Medicaid.....	-1	-2	-3	-3	-4	-6
Premiums.....	6	18	20	22	24	44
Total.....	-225	-344	-383	-441	-500	-952
141 Physician Fee Freeze:						
Freeze Nonparticipants.....	-225	-250	-320	-320	-340	-795
Medicaid.....	-5	-7	-9	-9	-8	-21
Premiums.....	35	48	60	61	60	143
Total.....	-195	-209	-269	-268	-288	-673
143 Premiums 25 percent Program 1988.....	0	0	-407	-568	-603	-407
Medicaid.....	0	0	20	28	30	20
Total.....	0	0	-387	-540	-573	-387
144 Reform Fees for HB Docs.....	0	0	0	0	0	0
145 OT Expanded Service.....	15	20	20	20	25	55
Medicaid.....	0	1	1	1	1	2
Premiums.....	-2	-4	-4	-4	-4	-10
Total.....	13	17	17	17	22	47
146 DME Rental Freeze.....	-35	-70	-105	-135	-180	-210
Medicaid.....	-1	-2	-3	-4	-5	-6
Premiums.....	6	14	19	25	31	39
Total.....	-30	-58	-89	-114	-154	-177
147 Assistant Surg/Cataracts.....	-25	-30	-30	-35	-35	-85
Medicaid.....	-1	-1	-1	-1	-1	-3
Premiums.....	4	5	5	5	5	14
Total.....	-22	-26	-26	-31	-31	-74
148 Prosthetic Lens for Cataract.....	-35	-40	-45	-50	-60	-120
Medicaid.....	-1	-1	-1	-1	-2	-3

COST ESTIMATES FOR WAYS AND MEANS CHANGES FROM BASELINE: CBO JULY 31, 1985—Continued

[Outlays, in millions of dollars, by fiscal year]

	1986	1987	1988	1989	1990	1986-88
Premiums.....	6	8	8	9	10	22
Total.....	-30	-33	-38	-42	-52	-101
149 Preventative Care Demos.....	1	1	1	1	1	3
Subtotal Entitlement.....	-2,184	-3,164	-4,386	-5,161	-5,733	-9,734
Subtotal Authorization.....	0	0	0	0	0	0
Subtotal Revenue.....	-53	-191	-293	-394	-537	-537
Deficit Reduction, Title I.....	-2,237	-3,355	-4,679	-5,555	-6,270	-10,271
TITLE II						
201 Benefits for Firm Relocation.....	NA	NA	NA	NA		NA
202 Liberalization of Employment Requirements.....	NA	NA	NA	NA		NA
203 Expansion of TAA Collection Period.....	NA	NA	NA	NA		NA
211 Petitions.....	NA	NA	NA	NA		NA
213 Technical Assistance.....	NA	NA	NA	NA		NA
221 Reauthorization of Current Program:						
Cash Benefits.....	0	0	0	0		0
Firm Assist. (Authorization).....	0	0	0	0	0	0
Empl. Services (Authorization).....	0	0	0	0		0
241 International Trade Commission (Authorization).....	3	(¹)	(¹)			3
242 Customs Service (Authorization).....	55	6	1	1		62
242 Customs Service (Revenue).....	-150	-38				-188
243 U.S. Trade Rep. (Authorization).....	(¹)	(¹)				(¹)
251 Customs User Fees.....	-75	-230	-240	-170		-545
Subtotal Entitlement.....	-75	-230	-240	-170	0	-545
Subtotal Authorization.....	58	6	1	1	0	65
Subtotal Revenue.....	-150	-38	0	0	0	-188
Deficit Reduction, Title II.....	-167	-262	-239	-169	0	-668
TITLE III						
301 Revise AFDC Quality Control.....	4	4	62	182	229	70
302 Block Grant For Teenage Pregnancy.....	50	100				150
303 Mandate AFDC Unemployed:						
Parent Program.....		100	160	180	185	260
Medicaid.....		95	150	175	185	245
Food Stamps.....		-35	-60	-70	-70	-95
Total.....	0	160	250	285	300	410
Subtotal Entitlement.....	54	264	312	467	529	630
Subtotal Authorization.....	0	0	0	0	0	0
Subtotal Revenue.....	0	0	0	0	0	0
Deficit Reduction, Title III.....	54	264	312	467	529	630
TITLE IV						
401 Railroad Retirement Unemployment Repayment Tax (Revenue).....	0	-101	-98	-4	0	-199
403 Supp. Unemployment Comp.....	(¹)	0	0	0	0	0
Subtotal Entitlement.....	0	0	0	0	0	0
Subtotal Authorization.....	0	0	0	0	0	0
Subtotal Revenue.....	0	-101	-98	-4	0	-199
Deficit Reduction, Title IV.....	0	-101	-98	-4	0	-199
TITLE V						
502 Cigarette Tax Ext. (Revenue).....	-1,536	-1,682	-1,686	-1,700	-1,705	-4,904
503 Increase Excise Tax on Coal (Revenue).....	-213	-229	-236	-246	-256	-678

COST ESTIMATES FOR WAYS AND MEANS CHANGES FROM BASELINE: CBO JULY 31, 1985—Continued

[Outlays, in millions of dollars, by fiscal year]

	1986	1987	1988	1989	1990	1986-88
504 Portion of RR Benefits Not Equivalent to SS						
Benefits Taxed as Ordinary Pension (Revenue)	-34	-62	-65	-65	-63	-161
505 Increase PBGC Premiums	-161	-212	-239	0	0	-612
Subtotal Entitlement	-161	-212	-239	0	0	-612
Subtotal Authorization	0	0	0	0	0	0
Subtotal Revenue	-1,783	-1,973	-1,987	-2,011	-2,024	-5,743
Deficit Reduction, Title V	-1,944	-2,185	-2,226	-2,011	-2,024	-6,355
Total Entitlement	-2,366	-3,342	-4,553	-4,864	-5,204	-10,261
Total Authorization	58	6	1	1	0	65
Total Revenue	-1,986	-2,303	-2,378	-2,409	-2,561	-6,667
Deficit Reduction, all Title	-4,294	-5,639	-6,930	-7,272	-7,765	-16,863

¹ Less than \$500,000.

NA—Not available.

Note.—Revenue increases appear as negative numbers because they reduce the deficit.

The following table shows changes from current law, where current law is not equal to baseline.

COST ESTIMATES FOR WAYS AND MEANS: CBO JULY 31, 1985

[Outlays, in millions of dollars, by fiscal year]

	1986	1987	1988	1989	1990	1986-88
221 Reauthorization of Current Program:						
Cash Benefits	70	70	70	70		0
Firm Assist. (Authorization)	17	24	28	29	9	0
Empl. Services (Authorization)	27	28	30	31		0
241 International Trade Commission (Authorization)	27	2	(¹)			29
242 Customs Service (Authorization)	672	81	12	12		765
243 U.S. Trade Rep. (Authorization)	12	2				14
Total Entitlement	70	70	70	70	0	0
Total Authorization	755	137	70	72	9	808
Total Revenue	0	0	0	0	0	0
Deficit Reduction	825	207	140	142	9	808

¹ Less than \$500,000.

TITLE I—MEDICARE

Section 101. The increase in the DRG rates for PPS hospitals on October 1, 1985 is fixed at 1 percent in this bill. Although the Administration has issued proposed regulations to freeze DRG rates during FY 1986, the baseline assumes a 5.6 percent increase. We estimate this bill would cost an additional \$305 million in 1986 and \$1.2 billion from 1986 through 1988 when compared to the proposed regulations.

Section 102. The transition to national DRG rates is frozen for one year. The freeze affects the allocation of payments but not the total amounts. Specifically, less efficient hospitals and those hospitals in higher cost regions will receive higher payments at the expense of more efficient hospitals and hospitals in lower cost re-

gions. The effects of this freeze on other provisions is explicitly accounted for in the CBO estimate for each provision affected by the freeze.

Section 104. The method of payment to hospitals for the indirect costs of teaching programs is reduced under this section. Although the savings for this provision above are \$1,830 million during fiscal years 1986-88, the gross savings are reduced by \$180 million to reflect payments to teaching hospitals under Section 105.

Section 105. The formula for the computation of payments for disproportionate share redistributes \$670 million from hospitals with few low-income patients to those with many. The gross costs of this provision are reduced to zero by the \$180 million in savings taken from Section 104 and by additional reductions in payments to hospitals with few low-income patients.

Section 107. The recently promulgated regulation freezing payments for Graduate Medical Education (GME) is not included in baseline Medicare outlays. Therefore, prohibiting the regulation is not a cost against baseline. CBO estimates that the prohibition results in \$130 million higher outlays in 1986 and \$45 million higher in 1987 compared with the Administration's freeze.

Section 108. The savings are based on our estimate that payments for returns on equity (ROE) will be approximately \$280 million in FY 1986. Payments to hospitals for ROE are eliminated for hospital fiscal years beginning after October 1, 1986. Payments to outpatient departments, nursing homes and home health agencies are reduced by a third beginning with institutional fiscal years beginning after October 1, 1985. The pattern of savings reflects the later effective date for the inpatient provision as well as the fact that proprietary hospitals have fiscal years that typically begin near the end of the federal fiscal year.

Section 121. Extending the hospice provision with higher than current rates results in additional outlays of less than \$500,000 annually. An extension of the hospice provision without increasing the rates would save approximately \$15 million during FY 1986-88. The cost of increasing the rates slightly more than offsets the savings from extending the program.

Section 123. Coverage of state and local workers. Section 123 extends Medicare coverage (Part A) to all state and local employees hired after December 31, 1985. Any state or local employee who leaves state or local employment and is later rehired by a state or local government is considered a new employee for purposes of this provision. This provision is effective January 1, 1986. The revenue increases are shown in the table. Over a five-year period, the outlay increases are insignificant.

Section 131. This section extends the working aged provisions of the Social Security Act to workers 70 years or older and their spouses. Three types of individuals are included in this provision: workers 70 or older, spouses over 65 of workers 70 or older, and spouses over 70 of workers under 65. By making Medicare a secondary payer for these workers and spouses, Medicare outlays would be reduced by an estimated \$990 million during the period 1986 to 1988.

Section 141. Physician Fee Freeze. Under current law, the customary and prevailing charges for all physician services are frozen for

a 15-month period which expires on October 1, 1985. During this period, nonparticipating physicians are prohibited from charging their Medicare beneficiaries more than they charged during a base period from April through June 1984.

This bill would extend the freeze for an additional 12-month period, expiring on October 1, 1986, for nonparticipating physicians only. The current prohibition on increases in actual charges of nonparticipating physicians would also be extended for 12 months, beginning October 1, 1985. On October 1, 1986, any physician who signs a participation agreement effective for the year beginning October 1, 1986 would receive an increase in Medicare payments. For physicians not signing a participation agreement, increases in the prevailing will be lagged one year behind those of participating physicians.

The CBO assumes that with the additional 12-month freeze, 50 percent of the reasonable charges for physicians will be participating dollars. This represents a shift of approximately 22 percent of non-participating reasonable charges to participating, based on the assumption that the 15-month freeze results in 35 percent of the reasonable charges being participating, and 65 percent, nonparticipating.

While participating physicians would be receiving allowed charges equivalent to amounts that would have been received by 1987 in the absence of any freeze, nonparticipating physicians who refused to participate in 1986 would not catch up to prefreeze reimbursements until 1990.

The Secretary would also be required to transfer \$15 million in Medicare Part B funds to the carriers for continued administration of the freeze and the participating physician program, and for the development of professional relations staffs dedicated exclusively to addressing the billing and other problems of participating physicians.

Section 143. Increasing Part B Premiums. Currently, premiums are set at 25 percent of SMI program costs for calendar years 1986 and 1987, and then based on COLA's for calendar years 1988, 1989, and 1990. Under this provision, premiums will be set at 25 percent of SMI program costs for calendar year 1988, changing the estimated monthly premium amount from \$19.40 to \$20.80 for that year.

Section 145. Occupational Therapists. This provision gives the same coverage under Medicare Part B for occupational therapists (OT) as is currently allowed for physical therapists (PT) for the three settings. The costs of coverage of OT services under Medicare for the private practice and SNF settings was based on Medicare payment data for PT services. The CBO estimate of the federal costs of extending Medicare coverage to OT's in rehabilitation agencies is based on the number of OT's in this particular setting relative to those in skilled nursing facilities.

Section 146. Durable Medical Equipment (DME) Rental Freeze. A one percent cap will be placed on the prevailing and customary charges for all rental durable medical equipment in fiscal year 1986. The prevailing charges for both rental and purchased DME would be increased thereafter by the CPI.

Section 147. Assistants Surgery Services for Routine Cataract Operations. This estimate was based on the Office of the Inspector

General (OIG) Audit Report dated June 7, 1985. For the 29 states included in their review, there were about 576,000 cataract operations paid by Medicare for inpatient and outpatient operations during calendar year 1983, of which about 88,000 operations had additional payments for assistant surgeon charges at a cost of approximately \$33 million.

Section 148. Prosthetic Lens for Cataracts. The CBO based its estimate on a General Accounting Office (GAO) study that gathered data from 7 carriers in 1982. The estimate has two components: the savings from a uniform screen limiting the number of replacement lenses that Medicare will pay for and the establishment of a reasonable charge allowance for prosthetic lenses and for the related professional service.

The estimated savings are based on cost data contained in the GAO study. CBO has attempted to extrapolate the data from the seven carriers examined in the GAO study to a national estimate.

Section 149. The demonstration program will fund no fewer than five demonstrations. Based on proposals submitted to DHHS the five projects are expected to average \$200,000 each for an annual total of \$1,000,000.

TITLE II—TRADE AND CUSTOMS LAWS AMENDMENTS

Section 201-205. The bill would make several changes to the worker adjustment assistance segment of the Trade Adjustment Assistance program. The provisions (1) providing benefits to workers whose firms have relocated overseas, (2) liberalizing employment requirements, and (3) expanding the period during which workers can receive benefits would probably increase costs, but no data exist to permit estimating the magnitude of such costs. The first of these three provisions has the potential to substantially increase spending. According to a paper written by Robert H. Frank and Richard T. Freeman for a 1978 Department of Labor conference on trade and employment—The Distributional Consequences of Direct Foreign Investment—every \$1 billion of direct private U.S. foreign investment seems to eliminate about 26,500 domestic jobs, both potential and existing. About \$4.5 billion of private U.S. capital was invested abroad in 1984. Based upon the above formulation, if U.S. firms were to transfer \$1 billion of their existing plant and equipment investment abroad and if all U.S. workers who lost their jobs as a result were to apply for trade adjustment benefits, we estimate that the cash benefit program could double in size.

Section 211-215. The bill would also make several changes affecting the eligibility and terms of the technical and financial assistance provided to firms that have been adversely impacted by competition from imported products.

It would expand eligibility for trade adjustment assistance to certain firms that experience a decline in sales and/or production of a critical product line. It would also eliminate the requirement that firms share in the cost of post-certification diagnostic and adjustment assistance, although it would not change the cost-sharing formula for implementation assistance. These two changes are likely to increase the demand from firms for assistance, although it is not possible at this time to estimate precisely this additional demand.

Furthermore, while appropriations could be increased, perhaps by several million dollars, to accommodate this demand, this would not necessarily be the case. For example, if the Congress did not provide additional funds to meet increased demand, fewer firms could be served, or the queue for assistance could lengthen, or the mix of assistance could be modified. Because of the uncertainty regarding the future level of appropriations for this program, the cost estimate reflects only the CBO baseline estimates for trade adjustment assistance to firms.

Section 221. The estimated costs of reauthorizing the current law individual cash benefit, training, and firm aid parts of the trade adjustment assistance program are consistent with the assumptions underlying the HBC baseline. Based upon recent certification levels, it is assumed that approximately 45,000 individuals will be certified under the cash benefit part of the program in fiscal year 1985, that 25,000 of these will receive first payments in fiscal year 1986, and that each will draw payments for an average of about 22 weeks. The estimates for the training and firm assistance portions of the program are based upon fiscal year 1985 appropriated levels that are inflated through time.

Section 241. The bill authorizes the appropriation of \$28.9 million for the International Trade Commission for fiscal year 1986. Outlays were estimated using historical outlays rates.

Section 242 authorizes the appropriation of \$777 million for the U.S. Customs Service for fiscal year 1986. This includes salaries and expenses for 800 new Customs Service personnel—500 inspectors, 150 import specialists, 100 customs patrol officers, and 50 special agents—to improve enforcement and compliance. Additional revenues generated by the new agents are estimated to be \$150 million in 1986 and \$38 million in 1987.

If the additional personnel continue to be employed by the Customs Service after 1986, costs to the federal government would be about \$30 million annually above baseline levels. Because the additional staffing would result in stricter enforcement and greater voluntary compliance, the government would collect additional revenues of \$412 million in 1987 and \$615 million each year thereafter.

Section 243. The authorization level for the Office of the U.S. Trade Representative is stated in the bill, and outlay estimates are based on historical spending patterns.

Section 251. Custom User Fees. The bill would require the Secretary of the Treasury to charge and collect fees to offset the costs of processing arrivals into the customs territory of the United States. Such fees, which vary in amount, would be charged for each arrival of a commercial vessel of 100 or more tons, a commercial truck, a railroad car, or a passenger aboard a commercial vessel, commercial aircraft, or train. An annual fee of \$25 would also be charged for all arrivals of private aircraft or private vessels. Assuming this bill is enacted on October 1, 1985, the Customs Service would begin to collect the fees 180 days later and would continue to collect them until April 1, 1989. The estimate of the amount of fees collected is based on projections of future arrivals which were derived from historical data on the number of arrivals in each category for recent years. It also reflects the loss of about \$25 million a year in

overtime fees that the Customs Service would collect under current law, but would be prohibited from collecting by the bill.

Based on information from the Customs Service, we expect that no significant additional costs would result from collecting the fees, because the necessary administrative structure already exists. The advisory committee that the bill would establish would result in additional costs of about \$30,000 per year.

TITLE III—AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

Section 301. Revise AFDC Quality Control. The current quality control system imposes fiscal sanctions on the states when their erroneous payments exceed certain tolerance levels. This bill would make major revisions in the quality control system so as to reduce the states' liabilities for sanctions. The basic error rate tolerance level would be increased from 3 percent to 3.5 percent. For states with an AFDC-UP program, with a higher than average percentage of earners on AFDC, and with a higher than average population density, the tolerance level would be increased further—to as high as 5.0 percent. At the same time, the measured error rate would be reduced. Technical errors—such as failure to get a Social Security number—would not be counted, and the estimated error rate for states with large sample sizes would be the lower bound rather than the midpoint of the range within which a state's true error rate falls. Finally, states would be allowed to choose an automatic waiver of their sanction if they were to spend additional administrative funds equal to one-half of their sanction amount on reducing error rates.

These changes would reduce expected fiscal sanctions by about three-quarters. Over the 1986-1990 period, federal costs would be an estimated \$481 million. These costs were based on reductions in the fiscal sanctions that CBO assumes would be collected under current law. Fiscal 1981 and 1982 sanctions are assumed to be collected in 1988; 1983 and 1984 sanctions in 1989; and 1985 and 1986 sanctions in 1990. The fiscal year 1981 sanctions have been assessed but CBO assumes they will not be collected until states have exhausted their judicial recourse. Further, CBO assumes that only 50 percent of the 1981 through 1983 sanction amounts will be collected and that only one-third of sanction amounts after 1983 will be collected because of waivers or court decisions.

Section 302. Authorize Grant to Reduce Teenage Pregnancy. In an attempt to reduce teenage pregnancies, the bill would authorize an appropriation of \$50 million in 1986 and \$100 million in 1987 for grants to states to be used to provide specified services targeted on young AFDC mothers who had not completed high school. The CBO estimates assumes that all the funds authorized would in fact be appropriated.

Section 303. Mandate AFDC-UP Program. Under current law, states may provide assistance to two-parent families in which the primary earner is unemployed. Twenty-four states and the District of Columbia provide such assistance. This bill would require the remaining 26 states to do so, effective October 1, 1986.

The CBO estimates that about 75,000 two-parent families would become new AFDC participants as a result of this provision. Their

benefits would average an estimated \$235 a month in 1987. Not all of the new participants would come onto AFDC immediately. CBO has assumed that on average during 1987 about 63 percent of these families would participate and during 1988, 95 percent. The federal share of benefit payments would be \$85 million in 1987 and \$160 million in 1990. Administrative costs would also rise because of the increase in participating families; the federal share of these costs would be estimated \$15 million in 1987 and \$25 million in 1990.

The estimates of new families and their average benefits were based on simulations from the Transfer Income Model (TRIM2). TRIM2 simulates numbers of families eligible for AFDC under current law and under alternative legislative changes, using income and demographic information reported in the Current Population Surveys of the Bureau of the Census. The TRIM2 estimates of families, based on 1984 incomes, were adjusted downward to allow for declining unemployment rates from 1984 to 1987.

TITLE IV—RAILROAD UNEMPLOYMENT TAX AND UNEMPLOYMENT COMPENSATION

Section 401 would increase the Railroad Retirement Unemployment Insurance (RRUI) repayment tax rates. The Railroad Retirement Solvency Act of 1983 established a repayment tax on the first \$7,000 in wages paid to a rail employee effective July 1, 1986 through September 30, 1990. Under current law the tax rate starts at 2.0 percent and will be increased by 0.3 percent a year. The bill would increase the initial tax rate by 2.3 percentage points in 1986, by 2.4 percentage points in 1987, and by 3.4 percentage points in 1988. That is, the bill would change the tax rates from 2.0 percent to 4.3 percent in 1986, from 2.3 percent to 4.7 percent in 1987, from 2.6 percent to 6.0 percent in 1988 and would retain the current law rates of 2.9 percent in 1989 and 3.2 percent in 1990. Estimated revenue effects appear in the table.

The bill would also extend the RRUI Account's authority to borrow from the Railroad Retirement Account effective October 1, 1985. In addition, the bill would impose a 3.5 percent surcharge on an annual wage base on \$7,000 if the RRUI Account has to borrow from the retirement account. Under current assumptions, the RRUI account will not need to borrow from the retirement account before 1991, therefore this provision has no revenue effect over the estimating period.

TITLE V—REVENUE PROVISIONS

Section 501 of Title V consists of a "sense of the Congress" statement that the Administration's proposed cuts in the Internal Revenue Service (IRS) budget should be restored and funds for revenue enforcement and related purposes should be increased to the levels recommended by the Committee on Appropriations. Because a "sense of the Congress" statement by itself does not achieve these actions, this cost estimate, therefore, shows no budgetary effects.

If the Treasury, Postal Service, and General Government Appropriation bill reported out of the Committee on Appropriations on July 18, 1985 were enacted and the staffing levels provided by that bill were maintained through 1990, then the associated costs and

the single-employer premium from \$2.60 to \$8.00 would result in an additional \$5.40 per participant in premium income. The increased premium collections would be credited to the public enterprise fund and a reduction in outlays would result.

6. Estimated cost to the State and local governments: Several Titles of this bill would have an effect on state and local government budgets. These estimated effects are shown in the following table.

[By fiscal year, in millions of dollars]

	1986	1987	1988	1989	1990
Title I-Medicaid.....	-7	-10	3	9	9
Title I-HI Tax for S&L.....	26	96	147	197	269
Title III.....	*	125	140	50	15
Total estimated State and local outlays.....	19	211	290	256	293

*Less than \$2.5 million.

Basis of Estimate:

Title I, which reduces expenditures in the Medicare program, would change Medicaid outlays. Because states share in the financing of Medicaid—paying about 55 percent of outlays—their expenditures would change. Reductions in Medicare outlays reduce state and local copayments for those beneficiaries with dual Medicare/Medicaid coverage. The increased Medicare premiums are a cost to state Medicaid programs. Beginning in FY 1988, the additional premiums are larger than savings from federal Medicare cut backs. State and local government will also have to pay the employers' share of the Hospital Insurance tax for new state and local employees.

Title III, which changes the AFDC program, would on balance increase states and local expenditures. The revision of AFDC quality control to reduce the states' liabilities for sanctions would lower expenditures in the same amount as the rise in federal expenditures. The grant to reduce teenage pregnancy would have no effect on states and localities; the bill requires that state spending supplement, and not replace, current spending on related programs. Finally, the requirement that states establish an AFDC-UP program would increase state and local expenditures, by \$125 million in 1987 and \$235 million in 1990. States share in the financing of AFDC and Medicaid outlays, which rise because of the AFDC-UP mandate. The state share of AFDC-UP benefits is estimated to be 63 percent; of Medicaid 61 percent; and of program administrative costs 50 percent.

Title IV would alter the tax treatment of certain Railroad Retirement benefits. States whose income tax bases depend on the federal income tax base may experience small state income tax increases because of the new tax treatment of some Railroad Retirement benefits.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Diane Burnside, Marianne Deignan, Neil Fisher, Debra Goldberg, Jim Hearn, Dick Hendrix, Steve Long, Mary Maginniss, Anne Manley, Kathleen O'Connell, Jan Peskin, Linda Radey, Jack Rodgers, and Steve Sheingold.

10. Estimate approved by: James L. Blum, Assistant Director for Budget Analysis.

3. New Budget Authority and Tax Expenditures

In compliance with subdivision (B) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, the Committee advises that the Congressional Budget Office cost estimate included above indicates that there is a reduction in new budget authority relative to baseline of \$349 million for fiscal year 1986 and there are no increased tax expenditures as a result of this bill.

D. Oversight by Committee on Government Operations

In compliance with subdivision (D) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, the Committee states that no oversight findings or recommendations have been submitted to this Committee by the Committee on Government Operations, regarding the provisions contained in this bill.

E. Inflation Impact

In compliance with clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee states that H.R. 3128, as reported, will reduce the Federal deficit by \$4.6 billion in fiscal year 1986, \$6.5 billion in fiscal year 1987, and \$8.1 billion in fiscal year 1988. The Committee believes that this reduction in the federal deficit, totaling \$19.2 billion over the three-year period of fiscal year 1986-1988, will have no inflationary impact on the economy, and may contribute to lower health prices and consumer prices generally.

IV. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in *italic*, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * *

TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

* * * * *

DEFINITION OF EMPLOYMENT

SEC. 210. For the purposes of this title—

Employment

(a) * * *

* * * * *

[Medicare Qualified Federal Employment

[(p) For purposes of sections 226 and 226A, the term "medicare qualified Federal employment" means any service which would constitute "employment" as defined in subsection (a) of this section but for the application of the provisions of subsection (a)(5).]

MEDICARE QUALIFIED GOVERNMENT EMPLOYMENT

(p)(1) For purposes of sections 226 and 226A, the term "medicare qualified government employment" means any service which would constitute "employment" as defined in subsection (a) of this section but for the application of the provisions of—

(A) subsection (a)(5), or

(B) subsection (a)(7), except as provided in paragraphs (2) and (3).

(2) Service shall not be treated as employment by reason of paragraph (1)(B) if the service is preformed—

(A) by an individual who is employed by a State or political subdivision thereof to relieve him from unemployment,

(B) in a hospital, home, or other institution by a patient or inmate thereof as an employee of a State or political subdivision thereof or of the District of Columbia,

(C) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency, or

(D) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training.

As used in this paragraph, the terms "State" and "political subdivision" have the meanings given those terms in section 218(b).

(3) Service performed for an employer shall not be treated as employment by reason of paragraph (1)(B) if—

(A) such service would be excluded from the term "employment" for purposes of this section if paragraph (1)(B) did not apply;

(B) such service is performed by an individual—

(i) who performing substantial and regular service for remuneration for that employer before January 1, 1986,

(ii) who is a bona fide employee of that employer on December 31, 1985, and

(iii) whose employment relationship with that employer was not entered into for purposes of meeting the requirements of this subparagraph; and

(C) the employment relationship with that employer has not been terminated after December 31, 1985.

(4) For purposes of paragraph (3), under regulations (consistent with regulations established under section 3121(u)(2)(D) of the Internal Revenue Code of 1954)—

(A) all agencies and instrumentalities of a State (as defined in section 218(b)) or of the District of Columbia shall be treated as a single employer, and

(B) all agencies and instrumentalities of a political subdivision of a State (as so defined) shall be treated as a single employer and shall not be treated as described in subparagraph (A).

* * * * *

ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS

SEC. 226. (a) Every individual who—

(1) has attained age 65, and

(2)(A) is entitled to monthly insurance benefits under section 202, would be entitled to those benefits except that he has not filed an application therefor (or application has not been made for a benefit the entitlement to which for any individual is a condition of entitlement therefor), or would be entitled to such benefits but for the failure of another individual, who meets all the criteria of entitlement to monthly insurance benefits, to meet such criteria throughout a month, and, in conformity with regulations of the Secretary, files an application for hospital insurance benefits under part A of title XVIII,

(B) is a qualified railroad retirement beneficiary, or

(C)(i) would meet the requirements of subparagraph (A) upon filing application for the monthly insurance benefits involved if **[medicare qualified Federal employment]** *medicare qualified government employment* (as defined in section 210(p)) were treated as employment (as defined in section 210(a)) for purposes of this title, and (ii) files an application, in conformity with regulations of the Secretary, for hospital insurance benefits under part A of title XVIII,

shall be entitled to hospital insurance benefits under part A of title XVIII for each month for which he meets the condition specified in paragraph (1), beginning with the first month after June 1966 for which he meets the conditions specified in paragraphs (1) and (2).

(b) Every individual who—

(1) has not attained age 65, and

(2)(A) * * *

* * * * *

(C)(i) * * *

(ii) would meet the requirements of subparagraph (A) (as determined under the disability criteria, including reviews, applied under this title), including the requirement that he has been entitled to the specified benefits for 24 months, if—

(I) **[medicare qualified Federal employment]** *medicare qualified government employment* (as defined in section

210(p)) were treated as employment (as defined in section 210(a)) for purposes of this title, and

* * * * *

(g) The Secretary and Director of the Office of Personnel Management shall jointly prescribe and carry out procedures designed to assure that all individuals who perform **[medicare qualified Federal employment]** *medical qualified government employment by virtue of service described in section 210(a)(5)* are fully informed with respect to (1) their eligibility or potential eligibility for hospital insurance benefits (based on such employment) under part A of title XVIII, (2) the requirements for and conditions of such eligibility, and (3) the necessity of timely application as a condition of entitlement under subsection (b)(2)(C), giving particular attention to individuals who apply for an annuity under chapter 83 of title 5, United States Code, or under another similar Federal retirement program, and whose eligibility for such an annuity is or would be based on a disability.

* * * * *

SPECIAL PROVISIONS RELATING TO COVERAGE UNDER MEDICARE PROGRAM FOR END STAGE RENAL DISEASE

SEC. 226A. (a) Notwithstanding any provision to the contrary in section 226 or title XVIII, every individual who—

(1)(A) is fully or currently insured (as such terms are defined in section 214), or would be fully or currently insured if (i) his service as an employee (as defined in the Railroad Retirement Act of 1974) after December 31, 1936, were included within the meaning of the term “employment” for purposes of this title, and (ii) his medicare qualified **[Federal]** *government* employment (as defined in section 210(p)) were included within the meaning of the term “employment” for purposes of this title;

(B)(i) is entitled to monthly insurance benefits under this title, (ii) is entitled to an annuity under the Railroad Retirement Act of 1974, or (iii) would be entitled to a monthly insurance benefit under this title if medicare qualified **[Federal]** *government* employment (as defined in section 210(p)) were included within the meaning of the term “employment” for purposes of this title; or

(C) is the spouse or dependent child (as defined in regulations) of an individual described in subparagraph (A) or (B);

(2) is medically determined to have end stage renal disease; and

(3) has filed an application for benefits under this section; shall, in accordance with the succeeding provisions of this section, be entitled to benefits under part A and eligible to enroll under part B of title XVIII, subject to the deductible, premium, and coin-surance provisions of that title.

* * * * *

TITLE IV—GRANTS TO STATES FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN AND FOR CHILD-WELFARE SERVICES

PART A—AID TO FAMILIES WITH DEPENDENT CHILDREN

* * * * *

STATE PLANS FOR AID AND SERVICES TO NEEDY FAMILIES WITH CHILDREN

SEC. 402. (a) A State plan for aid and services to needy families with children must—

(1) * * *

* * * * *

(38) provide that in making the determination under paragraph (7) with respect to a dependent child and applying paragraph (8), the State agency shall (except as otherwise provided in this part) include—

(A) any parent of such child, and

(B) any brother or sister of such child, if such brother or sister meets the conditions described in clauses (1) and (2) of section 406(a), if such parent, brother, or sister is living in the same home as the dependent child, and any income of or available of such parent, brother, or sister shall be included in making such determination and applying such paragraph with respect to the family (notwithstanding section 205(j), in the case of benefits provided under title II);

[and]

(39) provide that in making the determination under paragraph (7) with respect to a dependent child whose parent or legal guardian is under the age selected by the State pursuant to section 406(a)(2), the State agency shall (except as otherwise provided in this part) include any income of such minor's own parents or legal guardians who are living in the same home as such minor and dependent child, to the same extent that income of a stepparent is included under paragraph (31) [.] ; and

(40) provide that payments of aid will be made under the plan with respect to dependent children of unemployed parents, in accordance with section 407.

The Secretary may waive any of the requirements imposed under or in connection with paragraphs (13) and (14) of this subsection to the extent necessary to make such requirements compatible with the corresponding reporting and budgeting requirements by the Food Stamp Act of 1977.

* * * * *

PAYMENT TO STATES

SEC. 403. (a) * * *

* * * * *

[(i)(1)(A) Notwithstanding subsection (a)(1), if the ratio of a State's erroneous excess payments (as defined in subparagraph (C))

to its total payments under the State plan approved under this part exceeds—

- [(i) 0.04 for fiscal year 1983, or
- [(ii) 0.03 for any fiscal year thereafter,

then the Secretary shall make no payment for such fiscal year with respect to so much of the erroneous excess payments (as so defined) as exceeds the allowable error rate for such fiscal year.

[(B) The Secretary may waive, in certain limited cases, all or part of the reduction required under subparagraph (A) with respect to any State if such State is unable to reach the allowable error rate for a fiscal year despite a good faith effort by such State.

[(C) For purposes of this subsection, the term "erroneous excess payments" means the total of (i) payments to ineligible families, and (ii) overpayments to eligible families.

[(2) The State agency administering the plan approved under this part shall, at such times and in such form as the Secretary may specify, provide information on the rates of erroneous excess payments made in connection with its administration of such plan, together with any other data he requests that are reasonably necessary for him to carry out the provisions of this subsection.

[(3)(A) If a State fails to cooperate with the Secretary in providing information necessary to carry out this subsection, the Secretary, directly or through contractual or such other arrangements as he may find appropriate, shall establish the error rates for that State on the basis of the best data reasonably available to him and in accordance with such techniques for sampling and estimating as he finds appropriate.

[(B) In any case in which it is necessary for the Secretary to exercise his authority under subparagraph (A) to determine a State's error rate for a fiscal year, the amount that would otherwise be payable to such State under this part for quarters in such year shall be reduced by the costs incurred by the Secretary in making (directly or otherwise) such determination.

[(4) This subsection shall not apply with respect to Puerto Rico, Guam, or the Virgin Islands.]

(i)(1)(A) In order to establish and maintain improved quality control standards and procedures in the operation and administration of State plans approved under this part—

(i) each State, in accordance with a timetable and standards which shall be established by the Secretary in regulations, shall—

(I) collect a statistically reliable sample of the cases under its approved State plan under this part for each fiscal year or (at the option of the State) for each of the two six-month periods in such year, for purposes of quality control review under this subsection,

(II) review the sample so collected and (on the basis of such review) make its original findings with respect to errors for the period involved, and

(III) Submit such findings to the Secretary;

(ii) the Secretary, after studying the State's original findings as submitted under clause (i)(III), shall select specified cases for further review and notify the State thereof; and the State shall

submit to the Secretary the records of the cases so selected and specified.

(iii) the Secretary shall review and analyze the case records submitted under clause (ii) and (on the basis of such review and the State's original findings) shall determine the State's error rate for the period involved (without any adjustment under paragraph (2)(C)) and notify the State of such error rate within six months after the close of the fiscal year or within six months after the date on which the sample is submitted, whichever is later; and

(iv) the State shall develop and submit to the Secretary (except as provided by subparagraph (B)) a corrective action plan for eliminating or reducing errors identified as a result of the reviews under clauses (i) and (iii) (whether or not such errors are subject to inclusion for purposes of disallowances under paragraph (2)(A)) and, after such plan has been reviewed and approved by the Secretary in accordance with subparagraph (C), shall implement the corrective actions provided for in such plan in accordance with a timetable established by the Secretary in regulations; and the Secretary shall continuously monitor the State's corrective action process under such plan.

(B) The requirement (in subparagraph (A)(iv)) that States submit corrective action plans for eliminating or reducing errors may be waived by the Secretary in the case of any State which has consistently had an error rate below its error rate tolerance level (as determined by the Secretary, upon the request of the State, in the manner provided in subparagraphs (B) and (C)(i) of paragraph (2)).

(C) The Secretary shall establish criteria for corrective action plans submitted by States under subparagraph (A)(iv), and shall approve any plan so submitted upon determining that it meets such criteria. If a plan so submitted is disapproved, the Secretary shall specify (in notifying the State of such disapproval) the respect or respects in which the plan fails to meet the criteria so established, and shall provide appropriate advice and assistance to the State in eliminating such failure with the objective of facilitating the resubmission and approval of the plan at the earliest possible time.

(D) The sample obtained under subparagraph (A)(i) by a State which collected such sample on an annual basis rather than electing to collect two six-month samples for the fiscal year involved shall in no case include a smaller number of cases than the number that the Secretary determines would be required for a statistically reliable sample if the State had elected to collect two six-month samples for that fiscal year.

(E) The requirements imposed upon a State by subparagraph (A) with respect to the collection and review of samples and the submission of the results thereof, and the requirement that a State (under subparagraphs (A)(iv) and (C)) submit a corrective action plan which meets the Secretary's criteria established under subparagraph (C), shall be deemed for purposes of section 404 to be included in the State's plan approved under section 402.

(2)(A) Notwithstanding subsection (a)(1) but subject to subparagraph (C) and paragraph (3)), if a State's error rate for any fiscal year (as defined in paragraph (5)(A)) exceeds the error rate tolerance level determined for the State (for that year) under subparagraph

(B), then the Secretary shall disallow Federal payments for such fiscal year with respect to the State's erroneous payments (as defined in paragraph (5)(B)) to the extent that the inclusion of such erroneous payments in determining the State's error rate caused such rate to exceed the tolerance level so determined.

(B) A State's error rate tolerance level for any fiscal year shall be 3.5 percent, increased by—

(i) 0.5 percentage points if, throughout such fiscal year, the plan of such State approved under this part provides for the payment of aid with respect to dependent children of unemployed parents as provided in section 407,

(ii) 0.1 percentage points for each full 20 percent increment (up to a maximum of five such increments) by which (I) the ratio of the number of families with earned income who are receiving aid under such State's plan approved under this part to the total number of families receiving such aid exceeds (II) the average ratio, per State, of the number of families with earned income who are receiving aid under all of the State plans approved under this part to the total number of families receiving such aid, and

(iii) 0.1 percentage points for each full 20 percent increment (up to a maximum of five such increments) by which (I) the population per square mile of land area in such State exceeds (II) the average population per square mile of land area, per State, in all of the States having plans approved under this part.

(C) In determining the error rate in any State for purposes of this paragraph—

(i) such rate shall be fixed at the midpoint of the standard interval for errors within which the State's true error rate falls (as determined without regard to this clause on the basis of the sample or samples collected by the State under paragraph (1)(A)(i)), or at the lower bound of such standard interval in the case of a State which has collected a sample or samples sufficiently large to produce a lower limit of such interval no more than 2.5 percentage points below the midpoint; and

(ii) errors which are technical in nature, and which would not change the AFDC payment levels involved, shall be disregarded.

For purposes of clause (i), the lower limit of the standard interval for errors within which a State's true error rate falls shall be calculated in accordance with regulations prescribed by the Secretary to adjust for variability among the States in the number, proportion, or dollar value of cases in which the State's findings under paragraph (1)(A)(i)(II) (with respect to errors in its sample or samples collected under paragraph (1)(A)(i)(I)) differ from the Secretary's findings with respect to the State's error rate under paragraph (1)(A)(iii).

(D) The total amount of the disallowances that would otherwise be imposed with respect to any State under subparagraph (A) on account of an error rate in excess of the applicable error rate tolerance level for any fiscal year shall be reduced by the Federal share of any overpayments collected by such State (on account of erroneous payments) during that fiscal year.

(3)(A) The Secretary, in accordance with this paragraph, may waive all or any part of any disallowance that would otherwise be

imposed with respect to a State under paragraph (2)(A) if such State is unable to reach the applicable error rate tolerance level for the fiscal year involved despite a good-faith effort by such State.

(B) Any State may request a waiver of all or part of any disallowance that would otherwise be imposed with respect to such State for any fiscal year under paragraph (2)(A), basing such request upon a showing—

(i) that the State has made (and is continuing to make) a good-faith effort to reduce or eliminate the erroneous payments involved but was unable to reach the applicable error rate tolerance level for such fiscal year despite that effort; or

(ii) that (I) the Secretary's determination of the State's error rate for such fiscal year was made incorrectly or in a manner inconsistent with the provisions of this subsection, and (II) the State's error rate, if determined correctly and in a proper manner, would be lower than the rate so determined by the Secretary.

The Secretary shall consider and review such request, and either approve it or disapprove it in whole or in part, in accordance with a timetable which shall be specified in regulations. If the Secretary disapproves the request, the State may appeal the Secretary's decision to the Grant Appeals Board in the Department of Health and Human Services for such further action as may be provided for by law or regulations (including judicial review of the Secretary's decision or the Board's determination).

(C) In considering and reviewing any request for a waiver submitted by a State under this paragraph, the Secretary shall take into account—

(i) factors beyond the State's control (including disasters, strikes by State or other staff personnel engaged in determining eligibility or processing cases, sudden workload changes resulting from changes in Federal or State laws or regulations or from rapid caseload growth, and State actions resulting from incorrect policy interpretations by Federal officials);

(ii) factors relating to agency commitment, including demonstrated commitment by upper level State officials to the error reduction program under this subsection, the sufficiency and quality of operational systems designed to reduce errors, the use of effective systems and procedures for the statistical and program analysis of quality control and related data, and effective management and execution of the corrective action process;

(iii) the State's past performance with respect to erroneous payments, including past error rate levels and past error rate reduction efforts;

(iv) the cost effectiveness of error rate reduction, both in general and in the particular circumstances existing within the State; and

(v) such other factors as the Secretary may determine to be appropriate, as specified in regulations or as detailed by the State in its waiver request.

The Secretary's regulations shall specify the factors to be considered and the criteria to be used in assessing waiver requests under this paragraph, and shall indicate the relative weight or importance of

each of such factors and criteria in order to assist State in determining the appropriateness of proposed requests.

(D) Notwithstanding the preceding provisions of this paragraph, the Secretary shall in any case grant a waiver requested by a State under subparagraph (B) for any fiscal year if such State's corrective action plan submitted under paragraph (1)(A)(iv) or (1)(C), or a separate plan for the reduction of errors submitted by such State along with its waiver request, provides in detail for the expenditure of additional State and local funds for the reduction of errors in such fiscal year in a total amount (over and above the amount of State and local funds that would otherwise be expended in such fiscal year for the administration of the State plan approved under this part) equal to or exceeding one-half of the net amount of the disallowances that would otherwise be imposed with respect to such State under paragraph (2)(A) for such fiscal year. Expenditures of additional State and local funds for the reduction of errors as provided for in the corrective action plan or separate plan described in the preceding sentence shall be considered (for purposes of subsection (a)) to be expenditures for the proper and efficient administration of the State plan approved under this part.

(4)(A) Each State agency administering a plan approved under this part shall, at such times and in such form as the Secretary may specify, provide information on the rates of erroneous payments made in connection with its administration of such plan, together with any other data which the Secretary may request that are reasonably necessary for the Secretary to carry out the provisions of this subsection.

(B) If a State fails to cooperate with the Secretary in providing information necessary to carry out this subsection, the Secretary, directly or through such contractual or other arrangements as the Secretary may find appropriate, shall establish the error rates for that State on the basis of the best data reasonably available and in accordance with such techniques for sampling and estimating as the Secretary may find appropriate.

(C) In any case in which it is necessary for the Secretary to exercise the authority under subparagraph (B) to determine a State's error rate for a fiscal year, the amount that would otherwise be payable to such State under this part for quarters in such year shall be reduced by the costs incurred by the Secretary in making such determination.

(5) For purposes of this subsection—

(A) the term "error rate," with respect to any State for any fiscal year, means the ratio of such State's erroneous payments for such year (as defined in subparagraph (B)) to its total payments under the State plan approved under this part for such year, determined (except as otherwise specifically provided) subject to the adjustments provided for in paragraph (2)(C); and

(B) the term "erroneous payments" means—

(i) payments to ineligible families receiving assistance, and

(ii) overpayments to eligible families receiving assistance.

(6) *This subsection shall not apply with respect to Puerto Rico, Guam, or the Virgin Islands.*

* * * * *

DEPENDENT CHILDREN OF UNEMPLOYED PARENTS

SEC. 407. (a) * * *

(b) **【The provisions of subsection (a) shall be applicable to a State if the State's plan approved under section 402—】** *In providing for the payment of aid under the State's plan approved under section 402 in the case of families which include dependent children within the meaning of subsection (a) of this section, as required by section 402(a)(40), the State's plan—*

(1) **【requires】** *shall require* the payment of aid to families with dependent children with respect to a dependent child as defined in subsection (a) when—

(A) whichever of such child's parents is the principal earner has not been employed (as determined in accordance with standards prescribed by the Secretary) for at least 30 days prior to the receipt of such aid,

(B) such parent has not without good cause, within such period (of not less than 30 days) as may be prescribed by the Secretary, refused a bona fide offer of employment or training for employment, and

(C)(i) such parent has 6 or more quarters of work (as defined in subsection (d)(1)) , *including 2 or more quarters of work as defined in subsection (d)(1)(A)*, in any 13-calendar-quarter period ending within one year prior to the application for such aid or (ii) such parent received unemployment compensation under an unemployment compensation law of a State or of the United States, or such parent was qualified (within the meaning of subsection (d)(3)) for unemployment compensation under the unemployment compensation law of the State, within one year prior to the application for such aid; and

(2) **【provides】** *shall provide—*

(A) for such assurances as will satisfy the Secretary that unemployed parents of dependent children as defined in subsection (a) will be certified to the Secretary of Labor as provided in section 402(a)(19) within 30 days after receipt of aid with respect to such children;

(B) for entering into cooperative arrangements with the State agency responsible for administering or supervising the administration of vocational education in the State, designed to assure maximum utilization of available public vocational education services and facilities in the State in order to encourage the retraining of individuals capable of being retrained;

(C) for the denial of aid to families with dependent children to any child or relative specified in subsection (a)—

(i) if and for so long as such child's parent described in paragraph (1)(A), unless exempt under section 402(a)(19)(A), is not currently registered pursuant to such section for the work incentive program estab-

lished under part C of this title, or, if he is exempt under such section by reason of clause (iii) thereof or no such program in which he can effectively participate has been established or provided under section 432(a), is not registered with the public employment offices in the State, and

(ii) with respect to any week for which such child's parent described in paragraph (1)(A) qualifies for unemployment compensation under an unemployment compensation law of a State or of the United States, but refuses to apply for or accept such unemployment compensation; and

(D) for the reduction of the aid to families with dependent children otherwise payable to any child or relative specified in subsection (a) by the amount of any unemployment compensation that such child's parent described in paragraph (1)(A) receives under an unemployment compensation law of a State or of the United States.

* * * * *

(d) For purposes of this section—

(1) the term “quarter of work” with respect to any individual means a calendar quarter (A) in which such individual received earned income of not less than \$50 (or which is a “quarter of coverage” as defined in section 213(a)(2)), or in which such individual participated in a community work experience program under section 409, or the work incentive program established under part C, or (B) *if the State plan so provides (but subject to the last sentence of this subsection), in which such individual (i) was in regular full-time attendance as a student at an elementary or secondary school, (ii) was in regular full-time attendance in a course of vocational or technical training designed to fit him or her for gainful employment, or (iii) participated in an education or training program established under the Job Training Partnership Act;*

(2) the term “calendar quarter” means a period of 3 consecutive calendar months ending on March 31, June 30, September 30, or December 31;

(3) an individual shall, for purposes of section 407(b)(1)(C), be deemed qualified for unemployment compensation under the State's unemployment compensation law if—

(A) he would have been eligible to receive such unemployment compensation upon filing application, or

(B) he performed work not covered under such law and such work, if it had been covered, would (together with any covered work he performed) have made him eligible to receive such unemployment compensation upon filing application; and

(4) the phrase “whichever of such child's parents is the principal earner”, in the case of any child, means whichever parent, in a home in which both parents of such child are living, earned the greater amount of income in the 24-month period the last month of which immediately precedes the month in which an application is filed for aid under this part

on the basis of the unemployment of a parent, for each consecutive month for which the family receives such aid on that basis.

No individual shall be credited during his or her lifetime (for purposes of subsection (b)(1)(C)(i)) with more than 4 "quarters of work" based on attendance in a course or courses of vocational or technical training as described in paragraph (1)(B)(ii) of this subsection.

* * * * *

GRANTS FOR PROGRAMS TO PREVENT TEENAGE PREGNANCIES AND TO ASSIST PREGNANT INDIVIDUALS AND TEENAGE PARENTS OF YOUNG CHILDREN IN ACHIEVING SELF-SUFFICIENCY

SEC. 416. (a)(1) For the purpose of assisting States and localities in establishing and carrying out programs—

(A) to reduce the rate of teenage pregnancies in AFDC families; and

(B) to help pregnant individuals and teenage parents of young children in such families, who might otherwise become long-term recipients of aid to families with dependent children, in achieving self-sufficiency,

there are authorized to be appropriated the sum of \$50,000,000 for the fiscal year 1986 and the sum of \$100,000,000 for the fiscal year 1987, to be used by the Secretary in making grants for such programs in accordance with this section. Any State which provides for the establishment and carrying out of one or more such programs in accordance with this section shall be entitled to receive a grant under this section for each such fiscal year, in an amount determined under subsection (d).

(2) The State agency administering or supervising the administration of the State's plan approved under section 402 shall be responsible for administering or supervising the administration of the State's programs described in paragraph (1) for which grants under this section are made. Such grants shall be made directly to the State agency, and may be—

(A) used by such agency for the purpose of conducting and providing in accordance with this section (directly or under contracts with others) the activities and services required to carry out the program or programs involved, or

(B) paid by such agency to local school districts or to other local agencies or public or private nonprofit entities meeting the requirements of this section, under arrangements made with such districts or (through such districts) with such other agencies and entities, for use by such districts, agencies, or entities in conducting and providing in accordance with this section (directly or under contracts with others) the activities and services required to carry out the program or programs involved;

but such grants may be used only in areas which are determined by the State agency to be areas of high teenage pregnancy or high infant mortality, and it must be the objective of any program for which such grants are used to carry out both the purpose described in subparagraph (A) of paragraph (1) and the purpose described in subparagraph (B) of such paragraph.

(3) In order to qualify for a grant under this section for any fiscal year with respect to a program or programs described in paragraph (1) in any State, the State agency must submit to the Secretary no later than 3 months after the beginning of such year, in such manner and form as the Secretary may prescribe, a full and complete description of the program together with satisfactory assurances that the program will be operated in an effective and efficient manner and will otherwise meet the requirements of this section.

(4) Grants made under this section—

(A) shall be in addition to any amounts payable to States under section 403, and shall supplement and not replace any other funds which may be available for the same general purposes, or for the provision of services of any kind to needy individuals, in the localities involved, and

(B) shall not be used to provide any individual with services which are available to that individual under a State plan approved under section 1902.

(b)(1) In carrying out the purpose described in subparagraph (A) of subsection (a)(1), it shall be the objective of each program under this section (subject to the availability of funds) to—

(A) conduct activities and provide services which may help to reduce pregnancies among children, targeting such activities and services to children who are eligible for aid to families with dependent children, in order to assure that such children will not be prevented from achieving self-sufficiency by parental responsibilities imposed upon them before they reach adulthood;

(B) identify and address all of the factors which may play important roles in determining teenage sexual activity and contraceptive use;

(C) encourage active participation by the parents of the children involved in the activities and services being conducted or provided under the program; and

(D) encourage the children involved to develop education and employment goals for the future, combining new and existing resources to assist such children in achieving those goals and encouraging such children to postpone sexual activity and child bearing and to assume responsibility for family planning in order to achieve them.

(2)(A) To the maximum extent appropriate and feasible, the activities conducted and services provided in carrying out the purpose described in subparagraph (A) of subsection (a)(1) shall include the services which are made available to pregnant individuals and teenage parents with young children under the program as more specifically described in subsection (c).

(B) None of the activities conducted or services provided under this subsection or subsection (c) as a part of any program under this section may include the performance of abortions, or include the counseling of individuals to have abortions except where the life of the mother would be endangered if the fetus were carried to term.

(c)(1) In carrying out the purpose described in subparagraph (B) of subsection (a)(1), it shall be the objective of each program under this section (subject to the availability of funds) to help achieve self-sufficiency for individuals under the age of 25 who are eligible for aid to families with dependent children, who (at the start of their par-

participation in the program) are pregnant or are teenage parents with children under the age of 6, and who voluntarily elect to participate in the program, by—

(A) requiring such individuals to seek a high school diploma or its equivalent or to take part in appropriate training,

(B) providing each participant with academic or vocational training, job counseling, employment readiness, and job placement services,

(C) integrating and coordinating services otherwise available to participants, and

(D) providing each participant with other services and assistance designed to meet such objective, including an individualized assessment and plan, as more particularly described in paragraph (3).

(2) Participation in program activities conducted and services provided with the objective specified in paragraph (1) shall be limited to individuals under the age of 25 residing within the area covered by the program who are pregnant, or who are teenage parents of dependent children under the age of 6, and shall include any such individual only if he or she (at the time of initial participation in the program)—

(A) has not graduated from high school or its equivalent, and

(B) voluntarily elects (subject to subsection (e)) to participate; and the funds made available under this section may be used only for activities and services so conducted or provided in the case of individuals (described in the preceding provisions of this paragraph) who are eligible under this part (individually or as members of families) for aid to families with dependent children under the State's plan approved under section 402, or whose children are eligible for such aid.

(3) A program described in subsection (a)(1) meets the requirements of this section only if the activities conducted and services provided with the objective specified in paragraph (1) include—

(A) provision for the assignment to each participant of an agency staff person who, utilizing the case management approach and in coordination with the participant, will establish an individualized program, based on an individualized assessment of need and set forth in an individualized written plan, to meet the health needs of the participant and his or her dependent (or unborn) child, and to ensure the provision and coordination (on behalf of such participant and child) of such other services as the state determines to be necessary or appropriate to carry out the objective of this section, including, at a minimum, academic and vocational services, health services, training in parenting skills, job counseling, employment readiness, job placement, transportation, and child day care;

(B) provision for the integration and coordination of services which are otherwise available at the local level to individuals under age 25 who are pregnant or are teenage parents with children under age 6 and which are offered under this part, under parts B and C of this title, under title V, under title XX, under the Job Training Partnership Act, and under other Federal and State programs that would assist in achieving the objectives of the program under this section;

(C) provision for the coordination (with the local school system) of academic and vocational programs leading to a high school diploma or its equivalent, with a requirement of active participation in an educational program leading to a high school diploma or its equivalent, or in an appropriate training program, as a condition of participation in the program under this section;

(D) provision for job counseling, training, employment readiness, and job placement and relevant supportive services independently or in conjunction with one or more programs of employment and training under this part or part C of this title, under the Job Training Partnership Act, or under another Federal or State law;

(E) provision of child care at the program site or of other child day care services which have been contracted for on a reimbursable basis, to the extent necessary for teenage parents to participate effectively in the program, with a requirement that such care and services meet applicable State and local standards and with emphasis upon services that are compatible with the goal of achieving self-sufficiency;

(F)(i) assurances that all such child care and services, and any transportation to and from work which may be necessary for a teenage parent or pregnant individual to participate effectively in the program, will be provided or arranged for without any charge to such parent or individual while he or she is participating in any phase of the program, and

(ii) assurances that such care, services, and transportation will be provided or arranged for on a sliding scale basis (with charges based on ability to pay) during at least the first 6 months of work after the teenage parent or pregnant individual has completed his or her participation in the program, in order to ensure a smooth transition into the workforce;

(G) provision for variations in the selection and offering of services to individual participants to the extent necessary to take account of differences in the needs of such participants and in their age, family composition, cultural background, and geographic location;

(H) assurances that, in order to encourage participants to take advantage of the full range of services offered, as many of such services as possible will be provided at a single site, with programs and activities being conducted in the local schools to the maximum extent feasible;

(I) provision for the establishment of peer groups of participants, led by experienced group counselors, to enable such participants to meet and discuss program-related problems and issues and to share their common concerns, and to serve as a medium for the communication and dissemination of relevant information; and

(J) provision for the establishment of an outreach program designed to attract pregnant individuals and teenage parents of young children who would be eligible to participate.

Program activities conducted and services provided with the objective specified in paragraph (1) must include but need not be limited to the services and assistance set forth in the preceding provisions of

this paragraph, and may include such other health, family planning, educational, training, and social services as may be needed to achieve such objective in cases where the necessary funding is not available from other sources.

(4) In the case of a teenage parent participating in program activities conducted or services provided with the objective specified in paragraph (1), absences from his or her child for the purpose of attending a secondary or post-secondary school or participating in other education or training activities as a part of the program shall not be considered 'absences from the child' in determining whether he or she is exempted under clause (v) of section 402(a)(19)(A) from the requirement of registration under that section.

(5) As used in this section, the term "teenage parent" means a male or female individual who is the parent of a child under the age of 6 and who (A) has not attained the age of 20 or (B) became the parent of such child before attaining the age of 20.

(d)(1) The grant to which any State is entitled from the sum appropriated pursuant to subsection (a)(1) for any fiscal year shall be in an amount bearing the same ratio to the sum so appropriated as the amount expended by such State during the preceding fiscal year as aid to families with dependent children under its plan approved under section 402 bears to the total amount expended by all the States during such preceding year as aid to families with dependent children under their plans so approved.

(2) If any State does not qualify for a grant under this section for any fiscal year within the time provided in subsection (a)(3), the amount of the grant to which it would have been entitled for such year shall be reallocated to one or more other States on the basis of their relative need for additional assistance under this section (as determined by the Secretary).

(e) If any State wishes to require participation in activities and services provided under subsection (c) by all individuals who are eligible to participate in such activities and services (or would be eligible to so participate if they satisfied paragraph (2)(B) of such subsection) and with respect to whose participation funds made available under this section may be used, such State may request that the Secretary waive the requirement of such paragraph (2)(B) and permit the State to make participation mandatory for all such individuals. The Secretary shall grant any such request and permit the State to require participation by all such individuals if he or she determines that—

(1) the funds available for the program from Federal, State, local, and other sources (including this section) are sufficient to conduct all of the activities and provide all of the services which would be necessary to serve such individuals; and

(2) mandatory participation in the program by all such individuals can be effectively administered and enforced by the State and the locality or localities involved.

(f)(1) Prior to expenditure by a State of any grant payments made to it under this section for any fiscal year, the State shall report to the Secretary on the intended use of such payments; and such report shall be revised from time to time throughout the fiscal year involved if and to the extent that there are significant changes in such use.

(2) No later than March 1, 1987, each State shall submit to the Secretary a full and complete report on the activities carried out with the proceeds of the grant or grants theretofore made to it under this section. The report—

(A) shall be in such form and contain such information as may be necessary to provide an accurate description of such activities, to provide a complete record of the purposes for which the grant funds were spent, to indicate the extent to which such funds were spent in a manner consistent with the report or reports submitted under paragraph (1), and to indicate the extent to which the expenditure of such funds succeeded in accomplishing the objectives for which the grant was made, and

(B) shall specifically contain such information as the Secretary may require in order to include in his or her evaluation under paragraph (3) the overall description referred to in subparagraph (B) thereof.

(3)(A) No later than July 1, 1987, the Secretary, on the basis of the reports submitted by a State under paragraphs (1) and (2) for the fiscal year 1986 and of such additional information as he or she may obtain or develop, shall evaluate the use by such State of the grant or grants made to it under this section for that year in the light of the purposes of this section, with the objective of appraising the achievements of the programs for which such grants were made and developing comprehensive information and data on the basis of which decisions can be made with respect to the improvement of such programs and the desirability of providing further assistance in subsequent years. The Secretary shall report such evaluation to the Congress.

(B) As a part of the evaluation under subparagraph (A) the Secretary shall include, at a minimum, a detailed overall description of the number and characteristics of the individuals served by the programs, the various kinds of activities conducted and services provided and the results achieved, and shall set forth in detail his or her findings and comments with respect to the various State programs and a statement of his or her plans and recommendations for the future.

(C) If as a result of the evaluation the Secretary determines that any such grant was used in a manner inconsistent with the purposes of this section or the objective stated in subparagraph (A) or if the reports submitted by the State were insufficient to indicate whether or not the grant was so used, the Secretary shall notify the State of his or her disapproval, and the inconsistent use of such grant shall be subject to sanctions of the type described in section 404(a) as though this section were a part of the approved State plan as such inconsistent use were a failure to comply with a provision required by section 402(a) to be included in such plan.

(g) Grant payments to a State under this section for any fiscal year—

(1) shall be used only for the specific purposes described in this section;

(2) may be made on an estimated basis in advance of the determination of the exact grant amount, with appropriate subsequent adjustments to take account of any error in the estimates; and

(3) shall be expended by such State in that fiscal year or in the succeeding fiscal year.

(h) Notwithstanding any other provision of this title, payments made and services provided to participants in a program under this section, as a direct consequence of their participation in such program, shall not be considered as income or resources for purposes of determining their eligibility (or the eligibility of any other persons) for aid under the State's plan approved under section 402, or for purposes of determining the level of such aid.

* * * * *

TITLE XI—GENERAL PROVISIONS AND PEER REVIEW

* * * * *

PART B—PEER REVIEW OF THE UTILIZATION AND QUALITY OF HEALTH CARE SERVICES

* * * * *

FUNCTIONS OF PEER REVIEW ORGANIZATIONS

SEC. 1154. (a) Any utilization and quality control peer review organizations entering into a contract with the Secretary under this part must perform the following functions:

(1) * * *

* * * * *

(8) The organization shall perform such duties and functions and assume such responsibilities and comply with such other requirements as may be required by this part or under regulations of the Secretary promulgated to carry out the provisions of this part or as may be required to carry out section 1862(a)(15).

* * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * *

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

DESCRIPTION OF PROGRAM

SEC. 1181. The insurance program for which entitlement is established by sections 226 and 226A provides basic protection against the costs of hospital, related post-hospital, home health services, and hospice care in accordance with this part of (1) individuals who are age 65 or over and are eligible for retirement benefits under title II of this Act (or would be eligible for such benefits if certain **[Federal]** government employment were covered employment under such title) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under title II of this Act (or would have been so

entitled to such benefits if certain **[Federal]** *government* employment were covered employment under such title) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

* * * * *

CONDITIONS OF ANY LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) * * *

* * * * *

Payment for Hospice Care

(i)(1)(A) * * *

[(B)] Notwithstanding subparagraph (A), the rate of payment per day for routine home care furnished during fiscal year 1985 shall be \$53.17.]

(B) Notwithstanding subparagraph (A) and for hospice care furnished on or after October 1, 1985, the daily rate of payment per day for routine home care shall be \$63.17 and the daily rate of payment for other services included in hospice care shall be the daily rate of payment recognized under subparagraph (A) as of July 1, 1985, increased by \$10.

(C) With respect to care and services furnished on or after October 1, **[1985,]** 1986, the Secretary shall, not less often than annually, review and make appropriate adjustments to the payment rate for routine home care and the payment rates for other services included in hospice care based on the costs that are reasonable and related to the costs of furnishing such care and services. The Secretary shall report to Congress on October 1 each year on such review and such adjustments and on the adequacy of the rates under this paragraph to ensure participation by an adequate number of hospice programs under this title.

* * * * *

HOSPITAL INSURANCE BENEFITS FOR UNINSURED INDIVIDUALS NOT OTHERWISE ELIGIBLE

SEC. 1818. (a) * * *

* * * * *

(c) The provisions of section 1837 (except subsection (f) thereof), section 1838, subsection (b) of section 1839, and subsections (f) and (h) of section 1840 shall apply to persons authorized to enroll under this section except that—

(1) * * *

* * * * *

(5) an individual's entitlement under this section shall terminate with the month before the first month in which he becomes eligible for hospital insurance benefits under section 226

of this Act or section 103 of the Social Security Amendments of 1965; and upon such termination, such individual shall be deemed, solely for purposes of hospital insurance entitlement, to have filed in such first month the application required to establish such entitlement; [and]

(6) termination of coverage for supplementary medical insurance shall result in simultaneous termination of hospital insurance benefits for uninsured individuals who are not otherwise entitled to benefits under this Act[.]; and

(7) *any percent increase effected under section 1839(b) in an individual's monthly premium may not exceed 10 percent and shall only apply to premiums paid during a period equal to twice the number of months in the full 12-month periods described in that section.*

* * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * *

SCOPE OF BENEFITS

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) * * *

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) * * *

* * * * *

[(C) outpatient physical therapy services, other than services to which the next to last sentence of section 1861(p) applies;]

(C) outpatient physical therapy services (other than services to which the second sentence of section 1861(p) applies) and outpatient occupational therapy services (other than services to which such sentence applies through the operation of section 1861(g));

* * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) * * *

* * * * *

(g) In the case of services described in the [next to last] *Second* sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than \$500 shall be considered as incurred expenses for purposes of subsections (a) and (b). *In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year,*

no more than \$500 shall be considered as incurred expenses for purposes of subsections (a) and (b).

* * * * *

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) * * *

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) * * *

* * * * *

(C) in the case of outpatient physical therapy services or *outpatient occupational therapy services*, (i) such services are or were required because the individual needed physical therapy services, or *occupational therapy services, respectively*, (ii) a plan for furnishing such services has been established by a physician or by the qualified physical therapist or *qualified occupational therapist, respectively* providing such services and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician;

* * * * *

For purposes of this section, the term “provider of services” shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) *(or meets the requirements of such section through the operation of section 1861(g))*, or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) *(or meets the requirements of such section through the operation of section 1861(g))*, but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or *(through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services.*

* * * * *

ENROLLMENT PERIODS

SEC. 1837. * * *

* * * * *

(i)(1) In the case of an individual who—

[(A) meets the conditions described in clauses (i) and (iii) of section 1862(b)(3)(A),]

(A) has attained the age of 65,

(B) at the time the individual first satisfies paragraph (1) or (2) of section 1836, is enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of the individual's (or the individual's spouse's) current employment, and

(C) has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (3).

(2) In the case of an individual who—

[(A) meets the conditions described in clauses (i) and (iii) of section 1862(b)(3)(A),

[(B) has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period and any subsequent special enrollment period under this subsection during which the individual was not enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of the individual's (or individual's spouse's) current employment, and]

(A) has attained the age of 65;

(B)(i) has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or (ii) is an individual described in paragraph (1)(B);

(C) has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of the individual's (or individual's spouse's) current employment; and

[(C)] (D) has not terminated enrollment under this section at any time at which the individual is not enrolled in such a group health plan by reason of the individual's (or individual's spouse's) current employment,

there shall be a special enrollment period described in paragraph (3).

[(3) The special enrollment period referred to in paragraphs (1) and (2) is the period—

[(A) beginning with the first day of the third month before the month in which the individual attains the age of 70 and ending seven months later, or

[(B) beginning with the first day of the first month in which the individual is no longer enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of current employment and ending seven months later,

whichever period results in earlier coverage.]

(3) The special enrollment period referred to in paragraphs (1) and (2) is the period beginning with the first day of the first month in which the individual is no longer enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of current employment and ending seven months later.

COVERAGE PERIOD

SEC. 1838. (a) * * *

* * * * *

[(e) Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to—

[(1) subparagraph (A) of section 1837(i)(3)—

[(A) before the month in which he attains the age of 70, the coverage period shall begin on the first day of the month in which he has attained the age of 70, or

[(B) in or after the month in which he attains the age of 70, the coverage period shall begin on the first day of the month following the month in which he so enrolls; or

[(2) subparagraph (B) of section 1837(i)(3)—

[(A) in the first month of the special enrollment period, the coverage period shall begin on the first day of such month, or

[(B) in a month after the first month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which he so enrolls.]]

(e) *Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1837(i)(3)—*

(1) in the first month of the special enrollment period, the coverage period shall begin on the first day of that month, or

(2) in a month after the first month of the special enrollment period, the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.

AMOUNT OF PREMIUMS

SEC. 1839 (a)(1) * * * *

* * * *

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (a) or (e) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account [months in which the individual has met the conditions specified in clauses (i) and (iii) of section 1862(b)(3)(A) and can demonstrate that the individual was enrolled in a group health plan described in clause (iv) of such section] *months during which the individual has attained that age of 65 and which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(3)(A)(iv)* by reason of the individual's (or the individual's spouse's) current employment. Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with re-

spect to any other continuous period of eligibility which such individual may have.

* * * * *

(e)(1) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month after December 1983 and prior to January [1988] 1984 shall be an amount equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month.

(2) Any increases in premium amounts taking effect prior to January [1988] 1989 by reason of paragraph (1) shall be taken into account for purposes of determining increases thereafter under subsection (a)(3).

(f)(1) If on cost-of-living increase becomes effective under section 215(i) in December of 1985 [or 1986], 1986, or 1987, the monthly premium of each individual enrolled under this part for each month in the succeeding year shall (except as otherwise provided in subsection (b)) be the same as the monthly premium (disregarding subsection (b)) of the individual for such December.

(2) If paragraph (1) does not apply to the monthly premiums for 1986 [or 1987], 1987 or 1988, if an individual is entitled to monthly benefits under section 202 or 223 for November and for December in the preceding year, and if the monthly premium for the December and for the following January is deducted from those benefits under section 1840(a)(1), the monthly premium for that individual for that January and for each of the succeeding 11 months for which he is entitled to benefits under section 202 or 203 shall (except as otherwise provided in subsection (b)) be the greater of—

(A) the monthly premium amount determined under subsection (a)(2) for that January reduced by the amount (if any) necessary to make the monthly benefits under section 202 or 223 for that December after the deduction of the monthly premium (disregarding subsection (b)) for the January at least equal to the monthly benefits under section 202 or 223 for the preceding November after the deduction of the premium (disregarding subsection (b)) for that individual for the December, or

(B) the monthly premium (disregarding subsection (b)) for that individual for the December.

For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 202 or 223.

* * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

(b)(1) * * *

* * * * *

(4)(A)(i) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 15-month period beginning July 1, 1984, the

Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

(ii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 12-month period beginning October 1, 1985, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning July 1, 1983.

(iii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during a 12-month period beginning on or after October 1, 1986, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the Secretary shall not set any level higher than the same level as was set for services furnished during the previous fiscal year for physicians who were participating physicians during that year.

(B)(i) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 15-month period beginning July 1, 1984, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983.

(ii) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 12-month period beginning October 1, 1985, by a physician who is not a participating physician (as defined in subsection (h)(1)) at the time of furnishing the services, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning July 1, 1983.

(C)(i) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during periods beginning after September 30, 1985, the Secretary shall treat the level as set under subparagraph (A)(i) as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)(i).

(ii) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the periods beginning after September 30, 1986, by a physician who was not a participating physician on that date, the Secretary shall treat the level as set under subparagraph (A)(ii) as having fully provided for the economic changes which would have been taken into account but for the limitations contained in subparagraph (A)(ii).

(D)(i) In determining the customary charges for physicians' services furnished during the 12-month period beginning October 1, 1985, or October 1, 1986, by a physician [who at no time for any services furnished during the 12-month period beginning October 1, 1984, was a participating physician (as defined in subsection (h)(1))] who was not a participating physician (as defined in subsection (h)(1)) on September 30, 1985, the Secretary shall not recognize increases in actual charges for services furnished during the 15-month period beginning on July 1, 1984, above the level of the phy-

sician's actual charges billed in the 3-month period ending on June 30, 1984.

(ii) *In determining the customary charges for physicians' services furnished during the 12-month period beginning October 1, 1986, or October 1, 1987, by a physician who is not a participating physician (as defined in subsection (h)(1)) on September 30, 1986, the Secretary shall not recognize increases in actual charges for services furnished during the 12-month period beginning on October 1, 1985, above the level of the physician's actual charges billed during the 3-month period ending on June 30, 1984.*

* * * * *

【The bill realigns the margins of subclause (7)(B)(ii) (III) and clause (7)(B)(iii) to conform to the margins of the other subclauses and clauses of the paragraph:】

(7)(A) * * *

(B) The customary charge for such services in a hospital shall be determined in accordance with regulations issued by the Secretary and taking into account the following factors:

(i) In the case of a physician who is not a teaching physician (as defined by the Secretary), the carrier shall take into account the amounts the physician charges for similar services in the physician's practice outside the teaching setting.

(ii) In the case of a teaching physician, if the hospital, its physicians, or other appropriate billing entity has established one or more schedules of charges which are collected for medical and surgical services, the carrier shall base payment under this title on the greatest of—

(I) the charges (other than nominal charges) which are most frequently collected in full or substantial part with respect to patients who were not entitled to benefits under this title and who were furnished services described in subclauses (I) and (II) of subparagraph (A)(i),

(II) the mean of the charges (other than nominal charges) which were collected in full or substantial part with respect to such patients, or

(III) 85 percent of the prevailing charges paid for similar services in the same locality.

(iii) If all the teaching physicians in a hospital agree to have payment made for all of their physician's services under this part furnished to patients in such hospital on the basis of an assignment described in paragraph (3)(B)(ii) or under the procedure described in section 1870(f)(1), the customary charge for such services shall be equal to 90 percent of the prevailing charges paid for similar services in the same locality.

(8) *The Secretary by regulation shall—*

(A) *describe the factors to be used in determining the cases (of particular items or services) in which the application of this subsection results in the determination of a reasonable charge that, by reason of its grossly excessive or grossly deficient amount, is not inherently reasonable, and*

(B) *provide in those cases for the factors that will be considered in establishing a reasonable charge that is realistic and equitable.*

(9) *In providing payment for cataract eyeglasses and cataract contact lenses, and professional services relating to them, under this part, each carrier shall—*

(A) *provide for separate determinations of the payment amount for the eyeglasses and lenses and of the payment amount for the professional services, and*

(B) *not recognize as reasonable for such eyeglasses and lenses more than such amount as the Secretary establishes in guidelines relating to the inherent reasonableness of charges for such eyeglasses and lenses.*

* * * * *

【The following new paragraphs (h)(4)–(h)(6) were formerly paragraphs (i)(2)–(i)(4):】

(h)(1) * * *

* * * * *

【2】(4) *At the beginning of each fiscal year the Secretary shall publish a directory directories (for appropriate local geographic areas) containing the name, address, and specialty of all participating physicians and suppliers (as defined in [subsection [h](1)] for that area for that fiscal year. [The] Each directory shall be organized to make the most useful presentation of the information (as determined by the Secretary) for individuals enrolled under this part.*

【3】(5) *The Secretary shall promptly notify individuals enrolled under this part of the publication of [such list and directory] the directories and shall make [such list and directory] the appropriate area directory or directories available in each district and branch office of the Social Security Administration, in the offices of carriers, and to senior citizen organizations.*

【4】(6) *The Secretary shall provide that [the list and directory] the directories shall be available for purchase by the public. The Secretary shall provide that each appropriate area directory is sent to each participating physician located in that area.*

(7) *The Secretary shall provide that each explanation of benefits provided under this part for services furnished in the United States, in conjunction with the payment of claims under section 1833(a)(1) (made other than on an assignment-related basis, described in paragraph (8)), shall include—*

(A) *a reminder of the participating physician and supplier program established under this subsection (including the limitation on charges that may be imposed by such physicians and suppliers), and*

(B) *the toll-free telephone number or numbers, maintained under paragraph (2), at which an individual enrolled under this part may obtain information on participating physicians and suppliers.*

(8) *For purposes of this title, a claim is considered to be paid on an “assignment-related basis” if the claim is paid on the basis of an assignment described in subsection (b)(3)(B)(ii), in accordance with subsection (b)(6)(B), or under the procedure described in section 1870(f)(1).*

[(i)(1) Each year the Secretary shall publish a list containing the name, address, specialty, and percent of claims submitted with respect to each physician and supplier during the preceding year that were paid on the basis of an assignment described in subsection (b)(3)(B)(ii), in accordance with subsection (b)(6)(B), or under the procedure described in section 1870(f)(1). The Secretary may limit such list to those physicians and suppliers who accepted such an assignment in a certain percentage of such physician's or supplier's billings or who provide at least a certain volume of services, as the Secretary may determine to be appropriate. Such list shall be organized by such geographical area as the Secretary determines, after consultation with carriers, would facilitate the use of such list be individuals enrolled under this part.]

(j)(1) [In the case of a physician who is not a participating physician, the Secretary shall monitor each such physician's actual charges to individuals enrolled under this part for physicians' services furnished during the 15-month period beginning July 1, 1984.] *In the case of a physician who is not a participating physician for items and services furnished during a portion of the 27-month period beginning July 1, 1984, the Secretary shall monitor the physician's actual charges to individuals enrolled under this part for physicians' services during that portion of that period.* If such physician knowingly and willfully bills individuals enrolled under this part for actual charges in excess of such physician's actual charges for the calendar quarter beginning on April 1, 1984, the Secretary may apply sanctions against such physician in accordance with paragraph (2).

(2) Subject to paragraph (3), the sanctions which the Secretary may apply under paragraph (1) *or subsection (l)* are—

(A) barring a physician from participation under the program under this title for a period not to exceed 5 years, in accordance with the procedures of paragraphs (2) and (3) of section 1862(d), or

(B) the imposition of civil monetary penalties and assessments, in the same manner as such penalties are authorized under section 1128A(a),

or both. No payment may be made under this title with respect to any item or service furnished by a physician during the period when he is barred from participation in the program under this title pursuant to this subsection.

(k)(1) *In determining the customary and prevailing charge levels under the third and fourth sentences of subsection (b)(3) for durable medical equipment furnished on a rental basis (other than under a lease-purchase agreement) during the 12-month period beginning on October 1, 1985, the Secretary shall not set any such level higher than 101 percent of the same level as was set for the 15-month period beginning July 1, 1984.*

(2) *Payment under this part for durable medical equipment furnished on a rental basis (other than under a lease-purchase agreement) may only be made on an assignment-related basis (as defined in subsection (h)(3)) or to a provider of services with an agreement in effect under section 1866.*

(3) *In the case of durable medical equipment, the prevailing charge levels determined for purposes of clause (ii) of the third sen-*

tence of subsection (b) for any 12-month period (beginning after September 30, 1986) may not exceed (in the aggregate) the levels determined under such clause (taking into account paragraph (1), if applicable) for the preceding 12-month period by a percentage which exceeds the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average), as published by the Secretary of Labor, for the 12-month period ending in March of that preceding 12-month period.

(1)(1) If a physician knowingly and willfully bills an individual enrolled under this part for actual charges for services as an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

(2) If a physician knowingly and willfully bills an individual enrolled under this part for actual charges that includes a charge for an assistant at surgery for which payment may not be made by reason of section 1862(a)(15), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

* * * * *

STUDY OF RELATIVE VALUE SCALE FOR PHYSICIANS' SERVICES

SEC. 1845. (a) The Secretary shall develop a relative value scale that establishes a numerical relationship among the various physicians' services for which payment may be made under this part.

(b) In developing the scale, the Secretary shall consider among other items—

(1) the report of the Office of Technology Assessment under section 2309 of the Deficit Reduction Act of 1984,

(2) the recommendations of the Prospective Payment Assessment Commission under section 1886(e)(7)(C), and

(3) factors with respect to the input costs for furnishing particular physicians' services, such as—

(A) the differences in costs of furnishing services in different settings,

(B) the differences in skill levels and training required to perform the services, and

(C) the time required, and risk involved, in furnishing different services.

(c) The Secretary shall complete the development of the relative value scale under this section, and report to Congress on the development, not later than April 1, 1987. The report shall include recommendations for the application of the scale to the payment for physicians' services furnished under this part on or after October 1, 1987.

PART C—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * *

Outpatient Occupational Therapy Services

(g) The term "outpatient occupational therapy services" has the meaning given the term "outpatient physical therapy services" in subsection (p), except that "occupational therapy" shall be substituted for "physical therapy" each place it appears therein.

* * * * *

Durable Medical Equipment

(n) The term "durable medical equipment" includes iron lungs, oxygen tents, hospital beds, and wheelchairs (which may include a power-operated vehicle that may be appropriately used as a wheelchair, but only where the use of such a vehicle is determined to be necessary on the basis of the individual's medical and physical condition and the vehicle meets such safety requirements as the Secretary may prescribe) used in the patient's home (including an institution used [as] at his home other than an institution that meets the requirements of subsection (e)(1) or (j)(1) of this section), whether furnished on a rental basis or purchased.

* * * * *

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) * * *

* * * * *

(D) outpatient physical therapy services and outpatient occupational therapy services;

* * * * *

Reasonable Cost

(v)(1)(A) * * *

(B) Such regulations in the case of extended care services furnished by proprietary facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any [fiscal] cost reporting period shall [not exceed one and one half times] be equal to the average of the rates of interest, for each of the months any part of which is

included in [such fiscal] the period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

* * * * *

(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute post-hospital extended care services if provided by a skilled nursing facility and a quality control and peer review organization (or, in the absence of such a qualified organization, the Secretary or such agent as the Secretary may designate) determines that inpatient hospital services for the individual are not medically necessary but post-hospital extended care services for the individual are medically necessary and such extended care services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this title at the payment rate described in clause (ii) during the period in which—

(I) such post-hospital extended care services for the individual are medically necessary and not otherwise available to the individual (as so determined),

(II) inpatient hospital services for the individual are not medically necessary, and

(III) the individual is entitled to have payment made for post-hospital extended care services under this title, except that if the Secretary determines that there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital, such payment shall be made (during such period) *on the basis of* the amount otherwise payable under part A with respect to inpatient hospital services.

* * * * *

(O)(i) In establishing an appropriate allowance for depreciation and for interest on capital indebtedness and (if applicable) a return on equity capital with respect to an asset of a hospital or skilled nursing facility which has undergone a change of ownership, such regulations shall provide, *except as provided in clause (iv)*, that the valuation of the asset after such change of ownership shall be the lesser of the allowable acquisition cost of such asset to the owner of record as of the date of the enactment of this subparagraph (or, in the case of an asset not in existence as of such date, the first owner of record of the asset after such date), or the acquisition cost of such asset to the new owner.

* * * * *

(iv) *In the case of the transfer of a hospital or skilled nursing facility from ownership by a State to ownership by a non-profit corporation without monetary consideration, clause (i) shall be applied without regard to the acquisition cost of the hospital or facility to the new owner.*

(P)(i) *Such regulations may not provide for any payment, with respect to the reasonable costs of inpatient hospital services, for a return on equity capital for hospitals.*

(ii) *If such regulations provide for the payment for a return on equity capital, the rate of return to be recognized, for determining the reasonable cost of services furnished in a cost reporting period, shall be equal to the average of the rates of interest, for each of the months any part of which is included in the period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.*

* * * * *

(5)(A) Where physical therapy services, occupational therapy services, speech therapy services, or other therapy services or services of other health-related personnel (other than physicians) are furnished under an arrangement with a provider of services or other organization, specified in the first sentence of section 1861(p) (including through the operation of section 1861(g)) the amount included in any payment to such provider or other organization under this title as the reasonable cost of such services (as furnished under such arrangements) shall not exceed an amount equal to the salary which would reasonably have been paid for such services (together with any additional costs that would have been incurred by the provider or other organization) to the person performing them if they had been performed in an employment relationship with such provider or other organization (rather than under such arrangement) plus the cost of such other expenses (including a reasonable allowance for traveltime and other reasonable types of expense related to any differences in acceptable methods of organization for the provision of such therapy) incurred by such person, as the Secretary may in regulations determine to be appropriate.

* * * * *

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) * * *

* * * * *

(13) where such expenses are for—

(A) the treatment of flat foot conditions and the prescription of supportive devices therefor,

(B) the treatment of subluxations of the foot, or

(C) routine foot care (including the cutting or removal of corns or calluses, the trimming of nails, and other routine hygienic care); [or]

(14 which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph) and which are furnished to an individual who is an inpatient of a hospital by an entity other than the hospital, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the hospital [.] ; or

(15) which are for services of an assistant at surgery in a cataract operation unless, before the surgery is performed, the appropriate utilization and quality control peer review organiza-

tion (under part B of title XI) has approved of the use of such an assistant in the surgical procedure based on the existence of complicating medical condition.

(b)(1) * * *

* * * * *

(3)(A)(i) Payment under this title may not be made, except as provided in clause (ii), with respect to any item or service furnished in any month during the period described in clause (iii) to an individual [who is under 70 years of age during any part of such month] (or to the spouse of such individual [, if the spouse is under 70 years of age during any part of such month]) who is employed at the time such item or service is furnished to the extent that payment with respect to expenses for such item or service has been made, or can reasonably be expected to be made, under a group health plan (as defined in clause (iv)) under which such individual is covered by reason of such employment.

* * * * *

(iii) The provisions of clauses (i) and (ii) shall apply to an individual only for the period beginning with the month in which such individual becomes entitled to benefits under this title under section 226(a) [and ending with the month before the month in which such individual attains the age of 70] and shall not include any month for which the individual would, upon application, be entitled to benefits under section 226A.

* * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * *

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1886, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A but for a denial or reduction of payments under section 1886(f)(2), [and]

(H) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14) (i) that are furnished to an individual who is an inpatient of the hospital, and (ii) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital[.], and

(I) in the case of a hospital, to comply with the requirements of section 1867 to the extent applicable.

* * * * *

(e) For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) *(or meets the requirements of such section through the operation of section 1861(g))*, or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) *(or meets the requirements of such section through the operation of section 1861(g))*, but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or *(through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services.*

* * * * *

EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN ACTING LABOR

SEC. 1867. (a) MEDICAL SCREENING REQUIREMENT.—*In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists or to determine if the individual is in active labor (within the meaning of subsection (e)(2)).*

(b) NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND ACTIVE LABOR.—*If any individual (whether or not eligible for benefits under this title) comes to the hospital and the individual is determined (through the screening described in subsection (a) or otherwise) to have an emergency medical condition or to be in active labor, the hospital must provide either—*

(1) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, unless the examination or treatment is refused, or

(2) for transfer of the patient to another medical facility in accordance with subsection (c).

(c) RESTRICTING TRANSFERS UNTIL PATIENT STABILIZED.—

(1) RULE.—*If a patient at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(4)(B)) or is in active labor, the hospital may not transfer the patient unless—*

(A) there has been a written determination by a physician (within the meaning of section 1861(r)(1)) that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the benefits obtained from the provision of appropriate medical treatment

at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer, and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

(2) **APPROPRIATE TRANSFER.**—An appropriate transfer to a medical facility is a transfer—

(A) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the patient,

(ii) has agreed to accept transfer of the patient and to provide appropriate medical treatment, and

(iii) is being provided appropriate medical records (or copies thereof) of the examination and treatment affected at the transferring facility,

(B) in which the transfer is effected through qualified personnel and transportation equipment, including the use of medically appropriate life support measures during the transfer; and

(C) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of patient transferred.

(d) **ENFORCEMENT.**—

(1) **AS REQUIREMENT OF MEDICARE PROVIDER AGREEMENT.**—Failure of a hospital to meet the requirements of this section subjects the hospital to termination of its medicare provider agreement under this title, in accordance with section 1866(b).

(2) **CIVIL MONETARY PENALTIES.**—In addition to the other grounds for imposition of a civil money penalty under section 1128A(a), a participating hospital that knowingly violates a requirement of this section is subject, under that section, to a civil money penalty of not more than \$25,000 for each such violation.

(3) **CIVIL ENFORCEMENT.**—Any person or entity that is adversely affected directly by a participating hospital's violation of a requirement of this section may bring an appropriate action, in an appropriate court of general jurisdiction of the State in which the hospital is located or in the appropriate Federal district court, for damages to the person arising from the violation and for such other equitable relief as may be appropriate to remedy the violation or deter subsequent violations.

(4) **CRIMINAL PENALTIES.**—

(A) **IN GENERAL.**—A responsible physician (as defined in subparagraph (B)) who—

(i) has professional responsibilities for the provision of a screening examination of a patient in the hospital's emergency department and either (I) knowingly fails to provide for any screening examination required under subsection (a) if the failure represents a gross deviation from the prevailing local standards of medical practice, or (II) provides for such a screening examination which is conducted in a manner that is so inappropriate as to represent a gross deviation from the prevailing local standards of medical practice, or

(ii) has professional responsibilities for the treatment of a patient, knows (or has reason to know) that the patient has an emergency medical condition or is in active labor, and who, within the staff and facilities available at the hospital, either (I) knowingly fails to carry out the individual's responsibilities to provide for treatment of the patient under subsection (b) if the failure represents a gross deviation from the prevailing local standards of medical practice, or (II) provides for such treatment in a manner that is so inappropriate as to represent a gross deviation from the prevailing local standards of medical practice, or

(iii) has professional responsibilities for the treatment of a patient, knows (or has reason to know) that either the patient has an emergency medical condition which has not been stabilized or the patient is in active labor, and either—

(I) knowingly transfers (or orders the transfer) of the patient other than to another medical facility, or

(II) knowingly transfers (or orders the transfer) of the patient to another medical facility, if the physician knows (or has reason to know) that the other facility does not have space available for the treatment of the patient and has not agreed to accept the patient,

shall be fined not more than \$100,000 or imprisoned not more than one year, or both; except that, if, as a direct result of the violation of this paragraph, the patient dies, the physician shall be fined not more than \$250,000 or imprisoned not more than five years, or both.

(B) RESPONSIBLE PHYSICIAN DEFINED.—As used in subparagraph (A), the term “responsible physician” means, with respect to a patient, a physician who—

(i) is employed by, or under contract with, a participating hospital, and

(ii) acting as such as employee or under such a contract, has professional responsibilities for the provision of examinations or treatments for the patient or transfers of the patient.

(e) DEFINITIONS.—In this section:

(1) The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(2) The term “active labor” means labor at a time at which—

(A) delivery is imminent,

(B) there is inadequate time to effect safe transfer to another hospital, or

(C) a transfer may pose a threat of the health and safety of the patient or the unborn child.

(3) The term "participating hospital" means hospital that has entered into a provider agreement under section 1866 and has, under the agreement, obligated itself to comply with the requirements of this section.

(4)(A) The term "to stabilize" means, with respect to a medical condition, to provide such medical treatment of the condition as may be necessary to assure that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

(B) The term "stabilized" means, with respect to a medical condition, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

(5) The term "transfer" means the movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(f) **PREEMPTION.**—The provision of this section do not preempt any State or local law requirement respecting hospitals, except to the extent that the requirement directly conflicts with a requirement of this section.

* * * * *

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a)(1)(A) The Secretary shall annually determine, and shall publish not later than September 7 before the calendar year concerned—

(i) a per capita rate of payment for each class of individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are entitled to benefits under part A and enrolled under part B, and

(ii) a per capita rate of payment for each class of individuals who are so enrolled with such an organization and who are enrolled under part B only.

For purposes of this section, the term "risk-sharing contract" means a contract entered into under subsection (g) and the term "reasonable cost reimbursement contract" means a contract entered into under subsection (h).

* * * * *

(3) **[Payments]** Subject to subsection (c)(7), payments under a contract to an eligible organization under paragraph (1) or (2) shall be instead of the amounts which (in the absence of the contract) would be otherwise payable, pursuant to sections 1814(b) and

1833(a), for services furnished by or through the organization to individuals enrolled with the organization under this section.

* * * * *

(6) **[If]** *Subject to subsection (c)(7), if an individual is enrolled under this section with an eligible organization having a risk-sharing contract, only the eligible organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.*

* * * * *

(c)(1) * * *

* * * * *

(3)(A)(i) * * *

* * * * *

(B) An individual may enroll under this section with an eligible organization in such manner as may be prescribed in regulations and may terminate his enrollment with the eligible organization as of the beginning of the first calendar month following **[a full calendar month after]** *the date on which the request is made for such termination (or, in the case of financial insolvency of the organization, as may be prescribed by regulations) or, in the case of such an organization with a reasonable cost reimbursement contract, as may be prescribed by regulations. In the case of an individual's termination of enrollment, the organization shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization and may not receive benefits under this title other than through the organization.*

(C) The Secretary may prescribe the procedures and conditions under which an eligible organization that has entered into a contract with the Secretary under this subsection may inform individuals eligible to enroll under this section with the organization about the organization, or may enroll such individuals with the organization. *No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization under this section unless (i) at least 45 days before its distribution, the organization has submitted the material to the Secretary for review and (ii) the Secretary has not disapproved the distribution of the material. The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.*

* * * * *

(7) A risk-sharing contract under this section shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B) as of the effective date of the individual's—

(A) enrollment with an eligible organization under this section—

(i) payment for such services until the date of the individual's discharge shall be made under this title as if the individual were not enrolled with the organization,

(ii) the organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(iii) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this section; or

(B) termination of enrollment with an eligible organization under this section—

(i) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(ii) payment for such services during the stay shall not be made under section 1886(d), and

(iii) the organization shall not receive any payment with respect to the individual under this section during the period the individual is not enrolled.

* * * * *

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a)(1)(A)(i) * * *

* * * * *

(b)(1) * * *

* * * * *

(3)(A) * * *

(B) For purposes of subparagraph (A) and subsection (d) and except as provided in subsection (e), the "applicable percentage increase" for any 12-month cost reporting period or fiscal year shall be equal to one-quarter of 1 percentage point plus the percentage, estimated by the Secretary before the beginning of the period or year, by which the cost of the mix of goods and services (including personnel costs but excluding non-operating costs) comprising routine, ancillary, and special care unit inpatient hospital services, based on an index of appropriately weighted indicators of changes in wages and prices which are representative of the mix of goods and services included in such inpatient hospital services, for such cost reporting period or fiscal year will exceed the cost of such mix of goods and services for the preceding 12-month cost reporting period or fiscal year. [In determining a percentage change under subsection (e)(4) with respect to discharges occurring in any cost reporting period or fiscal year beginning on or after October 1, 1985, and before October 1, 1986, the Secretary may not establish a percentage increase which exceeds the applicable percentage increase otherwise determined for that period or fiscal year under the preceding sentence.] *Notwithstanding the previous sentence or subsection (e), for purposes of subparagraph (A) for cost reporting periods beginning during fiscal year 1986 and for purposes of subsection*

(d)(3)(A) for discharges occurring during that fiscal year, the applicable percentage increase shall be one percent.

* * * * *

(c)(1) * * *

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(7) In the case of a State which made a request under paragraph (5) before December 31, 1984, for the approval of a State hospital reimbursement control system and which request was approved—

(A) in applying paragraphs (1)(C) and (6), a reference to a “36-month period” is deemed a reference to as “48-month period”, and

(B) in order to allow the State the opportunity to provide the assurances described in paragraph (1)(C) for a 48-month period, the Secretary may not discontinue payments under the system, under the authority of paragraph (3)(A) because the Secretary has reason to believe that such assurances are not being (or will not be) met, before July 1, 1986.

(d)(1)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating cost of inpatient hospital services (as defined in subsection (a)(4)) of subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—

(i) beginning on or after October 1, 1983, and before October 1, 1984, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the regional adjusted DRG prospective payment rate determined under paragraph (2) for such discharges;

(ii) beginning on or after October 1, 1984, and before October 1, [1986,] 1987, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the applicable combined adjusted DRG prospective payment rate determined under subparagraph (D) for such discharges; or

(iii) beginning on or after October 1, [1986,] 1987, is equal to the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges.

(B) As used in this section, the term “subsection (d) hospital” means a hospital located in one of the fifty States or the District of Columbia other than—

(i) a psychiatric hospital (as defined in section 1861(f)),

(ii) a rehabilitation hospital (as defined by the Secretary),

(iii) a hospital whose inpatients are predominantly individuals under 18 years of age, or

(iv) a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days; and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary).

(C) For purposes of this subsection, for cost reporting periods beginning, or discharges occurring—

(i) on or after October 1, 1983, and before October 1, 1984, the “target percentage” is 75 percent and the “DRG percentage” is 25 percent;

(ii) on or after October 1, 1984, and before October 1, [1985,] 1986, the “target percentage” is 50 percent and the “DRG percentage” is 50 percent; and

(iii) on or after October 1, [1985,] 1986, and before October 1. [1986,] 1987, the “target percentage” is 25 percent and the “DRG percentage” is 75 percent; and

(D) for purposes of subparagraph (A)(ii)(II), the “applicable combined adjusted DRG prospective payment rate” for cost reporting periods beginning, or discharges occurring—

(i) on or after October 1, 1984, and before October 1, [1985,] 1986, is a combined rate consisting of 25 percent of the national adjusted DRG prospective payment rate, and 75 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges; and

(ii) on or after October 1, [1985,] 1986, and before October 1, [1986,] 1987, is a combined rate consisting of 50 percent of the national adjusted DRG prospective payment rate, and 50 percent of the regional adjusted DRG prospective payment rate, determined under paragraph (3) for such discharges.

(2) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region, for which payment may be made under part A of this title. Each such rate shall be determined for hospitals located in urban or rural areas within the United States or within each such region, respectively, as follows:

(A) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.— * * *

* * * * *

(C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—

(i) excluding an estimate of indirect medical education costs (*taking into account, for discharges occurring after September 30, 1985, the amendments made by section 104(a) of the Medicare Budget Reconciliation Amendments of 1985*),

(ii) adjusting for variations among hospitals by area in the average hospital wage level, [and]

(iii) adjusting for variations in case mix among hospitals [.] , and

(iv) for discharges occurring during fiscal years 1986 and 1987, excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F).

* * * * *

(3) The Secretary shall determine a national adjusted DRG prospective payment rate, for each inpatient hospital discharge in a fiscal year after fiscal year 1984 involving inpatient hospital services of a subsection (d) hospital in the United States, and shall determine a regional adjusted DRG prospective payment rate for such discharges in each region for which payments may be made under part A of this title. Each such rate shall be determined for hospitals located in urban or rural areas within the United States and within each such region, respectively, as follows:

(A) UPDATING PREVIOUS STANDARDIZED AMOUNTS.—The Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph, increased **for fiscal year 1985** *for each of fiscal years 1985 and 1986* by the applicable percentage increase under subsection (b)(3)(B), and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4), and adjusted to reflect the most recent case-mix data available.

* * * * *

(C) (i) MAINTAINING BUDGET NEUTRALITY FOR FISCAL YEAR 1985.—**[The]** *For discharges occurring in fiscal year 1985, the Secretary shall adjust each of such average standardized amounts as may be required under subsection (e)(1)(B) for that fiscal year.*

(ii) REDUCING FOR SAVINGS FROM AMENDMENT TO INDIRECT TEACHING ADJUSTMENT FOR SUBSEQUENT FISCAL YEARS.—*For discharges occurring after fiscal year 1985, the Secretary shall further reduce each of the average standardized amounts (in a proportion which takes into account the differing effects of the standardization affected under paragraph (2)(C)(i)) so as to provide for a reduction in the total of the payments (attributable to this paragraph) made for discharges occurring during—*

(I) *each of fiscal years 1986 and 1987, of an amount equal to the estimated reduction in the additional payment amounts under paragraph (5)(B) that would have resulted from the enactment of the amendments made by section 104 of the Medicare Budget Reconciliation Amendments of 1985 if the factor described in clause (ii)(II) of paragraph (5)(B) were applied for each respective fiscal year instead of the factor described in clause (ii)(I) of that paragraph, and*

(II) *each fiscal year thereafter, of an amount equal to the estimated reduction in the additional payment amounts under paragraph (4)(B) for that fiscal year that has resulted from the enactment of the amendments made by section*

104 of the Medicare Budget Reconciliation Amendments of 1985.

(D) COMPUTING DRG-SPECIFIC RATES FOR URBAN AND RURAL HOSPITALS.—For each discharge classified within a diagnosis-related group, the Secretary shall establish for the fiscal year a national DRG prospective payment rate and shall establish a regional DRG prospective payment rate for each region, each of which is equal—

(i) for hospitals located in an urban area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted *or reduced* under subparagraph (C)) for the fiscal year for hospitals located in an urban area in the United States or that region, and

* * * * *

(ii) for hospitals located in a rural area in the United States or that region (respectively), to the product of—

(I) the average standardized amount (computed under subparagraph (A), reduced under subparagraph (B), and adjusted *or reduced* under subparagraph (C)) for the fiscal year for hospitals located in a rural area in the United States or that region, and

* * * * *

(5)(A)(i) * * *

* * * * *

(B)(i) The Secretary shall provide for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except that *for discharges occurring during fiscal years 1984 and 1985* in the computation under this subparagraph the Secretary shall use an educational adjustment factor equal to twice the factor provided under such regulations, *and except that for discharges for fiscal years after fiscal year 1985 the payment amount shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and the amount paid to the hospital under subparagraph (A), by (II) the indirect teaching adjustment factor described in clause (ii).* In determining such adjustment the Secretary shall not distinguish between those interns and residents who are employees of a hospital and those interns and residents who furnish services to a hospital but are not employees of such hospital.

(ii) *For purposes clause (i)(II), the indirect teaching adjustment factor for discharges occurring—*

(I) *during fiscal years 1986 and 1987, is equal to $2 \times [(1+r)^n - 1]$, where “r” is the ratio of the hospital’s full-time equivalent interns and residents (including those assigned to outpatient departments of the hospital) to beds and “n” is .405, or*

(II) after fiscal year 1987, is equal to $1.5 \times [(1+r)^n - 1]$, where "r" is the same as "r" under subclause (I) and "n" is 5795.

(C)(i) The Secretary shall provide for such exceptions and adjustments to the payment amounts established under this subsection as the Secretary deems appropriate to take into account the special needs of regional and national referral centers (including those hospitals of 500 or more beds located in rural areas), and of public or other hospitals that serve a significantly disproportionate number of patients who have low income or are entitled to benefits under part A of this title. A hospital which is classified as a rural hospital may appeal to the Secretary to be classified as a rural referral center under this clause on the basis of criteria (established by the Secretary) which shall allow the hospital to demonstrate that it should be so reclassified by reason of certain of its operating characteristics being similar to those of a typical urban hospital located in the same census region and which shall not require a rural osteopathic hospital to have more than 3,000 discharges in a year in order to be classified as a rural referral center. Such characteristics may include wages, scope of services, service area, and the mix of medical specialties. The Secretary shall publish the criteria not later than August 17, 1984, for implementation by October 1, 1984. An appeal allowed under this clause must be submitted to the Secretary (in such form and manner as the Secretary may prescribe) during the quarter before the first quarter of the hospital's cost reporting period (or, in the case of a cost reporting period beginning during October 1984, during the first quarter of that period), and the Secretary must make a final determination with respect to such appeal within 60 days after the date appeal was submitted. Any payment adjustments necessitated by a reclassification based upon the appeal shall be effective at the beginning of such cost reporting period.

* * * * *

(F)(i) The Secretary shall provide under this subparagraph, for discharges occurring during fiscal years 1986 and 1987, for an additional payment amount, for discharges occurring in a cost reporting period of a hospital, for a subsection (d) hospital that is located in an urban area, that has 100 or more beds, and that—

(I) serves a significantly disproportionate number of patients who have low income (as defined in clause (iv)(I)), or

(II) can demonstrate that its net inpatient care revenues (excluding any of such revenues attributable to this title or State plans approved under title XIX) during the cost reporting period for indigent care from State and local government sources exceed 30 percent of its total of such revenues during the period.

(ii) The amount of such payment for each discharge shall be the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) for that discharge multiplied by the disproportionate share adjustment percentage established under clause (iii) for the cost reporting period in which the discharge occurs.

(iii) *The disproportionate share adjustment percentage for a cost reporting period—*

(I) *for a hospital described in clause (i)(II) is equal to 16 percent, and*

(II) *for other hospitals is equal to seven-tenths of the excess low income patient percentage (as defined in clause (iv)(IV) for that period,*

but in no case may the percentage for any hospital for any period exceed 16 percent.

(iv) *In this subparagraph:*

(I) *A hospital "serves a significantly disproportionate number of patients who have low income" for a cost reporting period if the hospital has a low income patient percentage (as defined in subclause (II)) for that period which equals, or exceeds, 15 percent.*

(II) *The term "low income patient percentage" means, with respect to a cost reporting period of a hospital, the percentage of its total number of patient days of inpatient hospital services it provided during periods which are attributable to low income patients (as defined in subclause (III)).*

(III) *The term "low income patient" means, with respect to inpatient hospital services provided to a patient, a patient who was, or is determined to have been, entitled to medical assistance under title XIX with respect to some or all of such services during the hospital stay, and includes such an individual notwithstanding the fact that some or all of such services were actually paid for under this title.*

(IV) *The term "excess low income patient percentage" means, for a cost reporting of a hospital, the hospital's low income patient percentage (as defined in subclause (II)) for that period minus 15 percent.*

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(e)(1)(A) * * *

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(4) Taking into consideration the recommendations of the Commission, the Secretary shall determine for each fiscal year (beginning with fiscal year [1986,] 1987 the percentage change which will apply for purposes of this section as the applicable percentage increase (otherwise described in subsection (b)(3)(B)) for discharges in that fiscal year, and which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality.

* * * * *

[(6)(A) The Commission shall consist of 15 individuals. Members of the Commission shall first be appointed no later than April 1, 1984, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than seven members expire in any one year.]

(A)(i) *The Commission shall consist of 23 members. Fifteen members of the Commission shall first be appointed no later than April 1, 1984, and the remaining members shall first be appointed no*

later than January 1, 1986, for a term of three years, except that the Director may provide for such shorter terms as will insure that (on a continuing basis) the terms of no more than eight members expire in any one year. The Director shall appoint a member to serve as Chairman.

(ii) The Chairman of the Commission shall provide for two subcommittees of the Commission, one with functions and responsibilities relating primarily to hospital payment issues and the other with functions and responsibilities relating primarily to physician payment issues. The Chairman may assign members of the Commission to serve on either or both subcommittees of the Commission.

(B) The membership of the Commission shall provide expertise and experience in the provision and financing of health care, including physicians and registered professional nurses, employers, third party payors, representatives of consumer and elderly groups, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and individuals have expertise in the research and development of technological and scientific advances in health care. The Director shall seek nominations from a wide range of groups, including—

(i) national organizations representing physicians, including medical specialty organizations and registered professional nurses and other skilled health professionals;

(ii) national organizations representing hospitals, including teaching hospitals;

(iii) national organizations representing manufactures of health care products; and

(iv) national organizations representing the business community, health benefit programs, labor, and the elderly.

(C) Subject to such review as the Office deems necessary to assure the efficient administration of the Commission, the Commission may—

(i) employ and fix the compensation of an Executive Director (subject to the approval of the Director of the Office) and such other personnel (not to exceed [25] 35) as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

* * * * *

(I)(i) There are authorized be appropriated such sums as may be necessary to carry out the provisions of this paragraph.

(ii) [Eighty-five] Fifty percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and [15] 50 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

* * * * *

(7)(A) The Commission shall make recommendations to the Congress, not later than February 1 of each year (beginning with 1987), regarding adjustments to the reasonable charge levels for physicians' services recognized under section 1842(b) and changes in the methodology for determining the rates of payment, and for making

payment, for physicians' services under this title and other items and services under part B.

(B) In making its recommendations, the Commission shall—

(i) consider, and make recommendations on the feasibility and desirability of reducing the differences in payment amounts for physicians' services under part B which are based on differences in geographic location or specialty;

(ii) review the input costs (including time, professional skills, and risks) associated with the provision of different physicians' services;

(iii) identify those charges recognized as reasonable under section 1842(b) which are significantly out-of-line, based on the considerations of clauses (i) and (ii);

(iv) assess the likely impact of different adjustments in payment rates, particularly their impact on physician participation in the participation program established under section 1842(h) and on beneficiary access to necessary physicians' services;

(v) make recommendations on ways to increase physician participation in that participation program and the acceptance of payment under part B on an assignment-related basis;

(vi) make recommendations respecting the advisability and feasibility of making changes in the payment system for physicians' services under part B based on (I) the Secretary's study under section 603(b)(2) of the Social Security Amendments of 1983 (relating to payments for physicians' services furnished to hospital inpatients on the basis of diagnosis-related groups) and (II) the Office's report under section 2309 of the Deficit Reduction Act of 1984 (relating to physician reimbursement under part B);

(vii) identify those procedures, involving the use of assistants at surgery, for which payment for those assistants should not be made under this title; and

(viii) identify those procedures for which an opinion of a second physician should be required before payment is made under section 1845.

(C) The Commission also shall advise and make recommendations to the Secretary respecting the development of the relative value scale under paragraph (8).

* * * * *

(g) [1] If the Congress does not enact legislation, after the date of the enactment of this subsection and before October 1, 1986, respecting the payment under this title for capital-related costs for inpatient hospital services, no payment may be made under this title for capital-related costs of capital expenditures (as defined in section 1122(g) and except as provided in section 1122(j) for inpatient hospital services in a State, which expenditures are obligated after September 30, 1986, unless the State has an agreement with the Secretary under section 1122(b) and under the agreement the State has recommended approval of the capital expenditures.

[(2) The Secretary shall provide that the amount which is allowable with respect to reasonable costs of inpatient hospital services for which payment may be made under this title, for a return on equity capital for hospitals shall, for cost reporting periods begin-

ning on or after the date of the enactment of this subsection, be equal to amounts otherwise allowable under regulations in effect on March 1, 1983, except that the rate of return to be recognized shall be equal to the average of the rates of interest, for each of the months any part of which is included in the reporting period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.】

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PAYMENT TO SKILLED NURSING FACILITIES FOR ROUTINE SERVICE COSTS

SEC. 1888. (a) * * *

(b) With respect to a hospital Based skilled nursing facility, the Secretary shall recognize as reasonable the portion of the cost differences between hospital-based and freestanding skilled nursing facilities attributable to excess overhead allocations (as determined by the Secretary) resulting from the reimbursement principles under this title, [notwithstanding] *notwithstanding* the limits set forth in paragraph (3) or (4) of subsection (a).

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DEFICIT REDUCTION ACT OF 1984

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DIVISION B—SPENDING REDUCTION ACT OF 1984

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TITLE III—MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH AMENDMENTS

* * * * *

Subtitle A—Medicare amendments

PART I—REIMBURSEMENT AND BENEFIT CHANGES

* * * * *

SEC. 2306. (a) * * *

(b)(1) Section 1842(b)(3) of such Act is amended—

(A) in subparagraph (F), by striking out “June 30” and inserting in lieu thereof “September 30”;

(B) by striking out “July 1” each place it appears in the third and eighth sentences and inserting in lieu thereof in each instance “October 1”; and

(C) in the third sentence thereof, by striking out “during the last preceding calendar year elapsing prior to” and inserting in lieu thereof “during the 12-month period ending on the March 31 last preceding”.

(2) The amendments made by paragraph (1) shall apply to items and services furnished on or after October 1, 1985 *and to durable medical equipment furnished on or after July 1, 1985.*

* * * * *

(e) In addition to any funds otherwise provided for fiscal years 1984 [and 1985], 1985, and 1986 for payment to carriers under contracts entered into under section 1842 of the Social Security Act, there are transferred from the Federal Supplementary Medical Insurance Trust Fund, for payments to such carriers under such contracts to implement [the amendments made by this section,] subsections (b)(4), (h), and (j) of section 1842 of the Social Security Act, not less than \$8,000,000 for fiscal year 1984, and not less than \$15,000,000 [for fiscal year 1985.] for each of fiscal years 1985 and 1986. A significant proportion of such funds shall be used for the expansion of the participating physician and supplier program and for the development of professional relations staffs dedicated to addressing the billing and other problems of physicians and suppliers participating in that program.

* * * * *

PROSPECTIVE PAYMENT WAGE INDEX

SEC. 2316. (a) The Secretary of Health and Human Services, in consultation with the Secretary of Labor, shall conduct a study to develop an appropriate index for purposes of adjusting payment amounts under section 1886(d) of the Social Security Act to reflect area differences in average hospital wage levels, as required under paragraphs (2)(H) and (3)(E) of such section, taking into account wage differences of full time and part time workers. The Secretary of Health and Human Services shall report the results of such study to the Congress not later than 30 days after the date of the enactment of this Act, including any changes which the Secretary determines to be necessary to provide for an appropriate index.

[(b) The Secretary shall adjust the payment amounts for hospitals for cost reporting periods beginning on or after October 1, 1983, to reflect any changes made in the wage index pursuant to subsection (a). Any adjustment in such payments to take account of overpayments or underpayments for the first cost reporting period of a hospital to which section 1886(d) of the Social Security Act applies, shall be made by decreasing or increasing payments in the succeeding cost reporting period.]

(b) The Secretary shall adjust the payment amounts for hospitals for discharges occurring during fiscal year 1986 to reflect the changes the Secretary has proposed (in the Federal Register on June 10, 1985) in regulations respecting the hospital wage index under section 1886(d)(3)(E) of the Social Security Act, as that proposal relates to the use of total gross hospital wages. For discharges occurring after September 30, 1986, the Secretary shall provide for such periodic adjustments in the appropriate wage index used under that section as may be necessary, taking into account changes in the wage differences of full-time and part-time workers.

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TAX EQUITY AND FISCAL RESPONSIBILITY ACT OF 1982

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TITLE I—PROVISIONS RELATING TO SAVINGS IN HEALTH AND INCOME SECURITY PROGRAMS

Subtitle A—Medicare

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PART II—CHANGES IN BENEFITS, PREMIUMS, AND ENROLLMENT

* * * * *

HOSPICE CARE

SEC. 122. (a)(1) * * *

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(h)(1) [(A) Subject to subparagraph (B), the] *The* amendments made by this section apply to hospice care provided on or after November 1, 1983[, and before October 1, 1986.].

[(B) An individual who on October 1, 1986, has an election under section 1812(d)(1) of the Social Security Act in effect for a period, is entitled to hospice care benefits after that date during the remainder of that period and any consecutive period to which the individual would have been entitled before such date.]

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TITLE II—REVENUE MEASURES

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SUBTITLE F—EXCISE TAXES

* * * * *

PART III—CIGARETTES

SEC. 283. INCREASE IN TAX ON CIGARETTES.

(a) **RATE OF TAX.**—Subsection (b) of section 5701 (relating to rate of tax on cigarettes) is amended—

(1) by striking out “\$4” in paragraph (1) and inserting in lieu thereof “\$8”; and

(2) by striking out “\$8.40” in paragraph (2) and inserting in lieu thereof “\$16.80”.

(b) **FLOOR STOCKS.**—

(1) **IMPOSITION OF TAX.**—On cigarettes manufactured in or imported into the United States which are removed before January 1, 1983, and held on such date for sale by any person, there shall be imposed the following taxes:

(A) **SMALL CIGARETTES.**—On cigarettes, weighting not more than 3 pounds per thousand, \$4 per thousand;

(B) **LARGE CIGARETTES.**—On cigarettes, weighing more than 3 pounds per thousand, \$8.40 per thousand; except that, if more than 6½ inches in length, they shall be taxable at the rate prescribed for cigarettes weighing not more than 3 pounds per thousand, counting each 2¾ inches, or fraction thereof, of the length of each as one cigarette.

(2) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) **LIABILITY FOR TAX.**—A person holding cigarettes on January 1, 1983, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) **METHOD OF PAYMENT.**—The tax imposed by paragraph (1) shall be treated as a tax imposed under section 5701 and shall be due and payable on January 18, 1983 in the same manner as the tax imposed under such section is payable with respect to cigarettes removed on January 18, 1983.

(3) **CIGARETTE.**—For purposes of this subsection, the term “cigarette” shall have the meaning given to such term by subsection (b) of section 5702 of the Internal Revenue Code of 1954.

(4) **EXCEPTION FOR RETAILERS.**—The taxes imposed by paragraph (1) shall not apply to cigarettes in retail stocks held on January 1, 1983, at the place where intended to be sold at retail.

(c) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply with respect to cigarettes removed after December 31, 1982 [and before October 1, 1985.].

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INTERNAL REVENUE CODE OF 1954

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Subtitle A—Income Taxes

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CHAPTER 1—NORMAL TAXES AND SURTAXES

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Subchapter B—Computation of Taxable Income

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PART II—ITEMS SPECIFICALLY INCLUDED IN GROSS INCOME

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SEC. 86. SOCIAL SECURITY AND TIER 1 RAILROAD RETIREMENT BENEFITS.

(a) **IN GENERAL.**—Gross income for the taxable year of any taxpayer described in subsection (b) (notwithstanding section 207 of the Social Security Act) includes social security benefits in an amount equal to the lesser of—

(1) one-half of the social security benefits received during the taxable year, or

(2) one-half of the excess described in subsection (b)(1).

(b) **TAXPAYERS TO WHOM SUBSECTION (a) APPLIES.—**

(1) **IN GENERAL.**—A taxpayer is described in this subsection if—

(A) the sum of—

(i) the modified adjusted gross income of the taxpayer for the taxable year, plus

(ii) one-half of the social security benefits received during the taxable year, exceeds

(B) the base amount.

(2) **MODIFIED ADJUSTED GROSS INCOME.**—For purposes of this subsection, the term “modified adjusted gross income” means adjusted gross income—

(A) determined without regard to this section and sections 221, 911, 931, and 933, and

(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

(c) **BASE AMOUNT.**—For purposes of this section, the term “base amount” means—

(1) except as otherwise provided in this subsection, \$25,000,

(2) \$32,000, in the case of a joint return, and

(3) zero, in the case of a taxpayer who—

(A) is married at the close of the taxable year (within the meaning of section 143) but does not file a joint return for such year, and

(B) does not live apart from his spouse at all times during the taxable year.

(d) **SOCIAL SECURITY BENEFIT.**—

(1) **IN GENERAL.**—For purposes of this section, the term “social security benefit” means any amount received by the taxpayer by reason of entitlement to—

(A) a monthly benefit under title II of the Social Security Act, or

(B) a tier 1 railroad retirement benefit.

For purposes of the preceding sentence, the amount received by any taxpayer shall be determined as if the Social Security Act did not contain section 203(i) thereof.

(2) **ADJUSTMENT FOR REPAYMENT DURING YEAR.**—

(A) **IN GENERAL.**—For purposes of this section, the amount of social security benefits received during any taxable year shall be reduced by any repayment made by the taxpayer during the taxable year of a social security benefit previously received by the taxpayer (whether or not such benefit was received during the taxable year).

(B) **DENIAL OF DEDUCTION.**—If (but for this subparagraph) any portion of the repayments referred to in subparagraph (A) would have been allowable as a deduction for the taxable year under section 165, such portion shall be allowable as a deduction only to the extent it exceeds the social security benefits received by the taxpayer during the taxable year (and not repaid during such taxable year).

(3) **WORKMEN'S COMPENSATION BENEFITS SUBSTITUTED FOR SOCIAL SECURITY BENEFITS.**—For purposes of this section, if, by

reason of section 224 of the Social Security Act (or by reason of section 3(a)(1) of the Railroad Retirement Act of 1974), any social security benefit is reduced by reason of the receipt of a benefit under a workmen's compensation act, the term "social security benefit" includes that portion of such benefit received under the workmen's compensation act which equals such reduction.

[(4) **TIER 1 RAILROAD RETIREMENT BENEFIT.**—For purposes of paragraph (1), the term "tier 1 railroad retirement benefit" means a monthly benefit under section 3(a), 3(f)(3), 4(a), or 4(f) of the Railroad Retirement Act of 1974.]

(4) **TIER 1 RAILROAD RETIREMENT BENEFIT.**—For purposes of paragraph (1), the term "tier 1 railroad retirement benefit" means—

(A) *the amount of the annuity under the Railroad Retirement Act of 1974 equal to the amount of the benefit to which the taxpayer would have been entitled under the Social Security Act if all of the service after December 31, 1936, of the employee (on whose employment record the annuity is being paid) had been included in the term employment as defined in the Social Security Act, and*

(B) *a monthly annuity amount under section 3(f)(3) of the Railroad Retirement Act of 1974.*

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PART VI—ITEMIZED DEDUCTIONS FOR INDIVIDUALS AND CORPORATIONS

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SEC. 162. TRADE OR BUSINESS EXPENSES.

(a) **IN GENERAL.**—* * *

* * * * *

(i) **GROUP HEALTH PLANS.**—

(1) **[GENERAL RULE] COVERAGE RELATING TO END STAGE RENAL DISEASE.**—The expenses paid or incurred by an employer for a group health plan shall not be allowed as a deduction under this section if the plan differentiates in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner.

(2) **CONTINUATION COVERAGE.**—

(A) **REQUIRING OPTION OF CONTINUATION COVERAGE WHEN QUALIFIED BENEFICIARY WOULD LOSE COVERAGE.**—*The expenses paid or incurred by an employer for a group health plan shall not be allowed as a deduction under this section unless each qualified beneficiary who would lose coverage under the plan because of a qualifying event is given, in accordance with this paragraph, the option of electing continuation coverage under the plan.*

(B) **ELECTION.**—

(i) **ELECTION PERIOD.**—*The option of electing continuation coverage must be offered during a period that—*

(I) begins not later than the termination date (as defined in subparagraph (C)(ii)),

(II) is of at least 60 days duration, and

(III) ends not earlier than 60 days after the date the qualified beneficiary is notified under subparagraph (F)(iv) or the termination date, whichever date is later.

(ii) **EFFECT OF ELECTION ON OTHER BENEFICIARIES.**—

Unless otherwise specified in the election, any such election by a qualified beneficiary described in subparagraph (G)(ii)(I) shall be deemed to include an election of continuation coverage on behalf of any other qualified beneficiary whose coverage would, but for continuation coverage provided in accordance with this paragraph, be affected by the qualifying event.

(C) **QUALIFYING EVENT AND TERMINATION DATE.**—For purposes of this paragraph—

(i) A “qualifying event” under a group health plan, with respect to a covered employee, is any of the following events if coverage of a qualified beneficiary under the plan would, but for continuation coverage provided in compliance with this paragraph, be terminated by the occurrence of the event:

(I) The death of the covered employee.

(II) The divorce or separation of the covered employee from the employee’s spouse.

(III) The covered employee becoming entitled to benefits under title XVIII of the Social Security Act.

(ii) The term “termination date” means, with respect to a qualifying event, the date on which coverage of a qualified beneficiary under a group health plan but for continuation coverage provided in compliance with this paragraph.

(D) **TERMS OF CONTINUATION COVERAGE.**—Any continuation coverage elected by or on behalf of a qualified beneficiary shall meet the following requirements:

(i) **NO REQUIREMENT OF INSURABILITY.**—The coverage may not be conditioned upon, or discriminate on the basis of lack of, evidence of insurability.

(ii) **CONTINUED BENEFITS.**—The coverage shall consist of coverage which is identical to the coverage provided under the plan to similarly situated beneficiaries under the plan with respect to whom a qualifying event has not occurred.

(iii) **PERIOD OF CONTINUED COVERAGE.**—The coverage shall be for a period commencing upon the termination date and ending not earlier than the earliest of the following:

(I) **MAXIMUM OF FIVE YEARS.**—Five years after the termination date.

(II) **END OF PLAN.**—The date on which the employer ceases to provide any group health plan to employees.

(III) *FAILURE TO PAY PREMIUMS.*—The date on which there is a failure in making timely payment of any premium required under the plan with respect to the qualified beneficiary.

(IV) *REEMPLOYMENT OR MEDICARE ELIGIBILITY.*—The date on which the qualified beneficiary first becomes or could become, after the date of the election, a covered employee under any other group health plan or becomes entitled to benefits under title XVIII of the Social Security Act.

(V) *REMARRIAGE OF SPOUSE.*—In the case of a qualified beneficiary described in subparagraph (G)(ii)(I), the date on which the beneficiary remarries and becomes (or could become) covered under a group health plan as the spouse of a covered employee.

(VI) *CHILD TURNING MAJORITY.*—In the case of any individual who is a qualified beneficiary by reason of having been a covered dependent child of a covered employee, the date on which the individual ceases to be a covered dependent child of the covered employee.

(iv) *CONVERSION OPTION.*—In the case of a qualified beneficiary whose period of continued coverage expires under clause (iii)(I), the plan must provide to the beneficiary, during the 180-day period ending on the date of expiration of the period of continued coverage, the option of enrollment under a conversion health plan otherwise generally available to beneficiaries under the plan.

(E) *PREMIUMS FOR CONTINUATION COVERAGE.*—

(i) *AMOUNT.*—The total premium charged by a group health plan with respect to any qualified beneficiary for continuation coverage under the plan shall not exceed the sum of employer premiums and employee premiums generally charged with respect to coverage under the plan of similarly situated beneficiaries with respect to whom a qualifying event has not occurred. The total of all premiums charged by the plan in any plan year may be based upon reasonably anticipated community costs for such plan year of the entire pool of covered employees and other beneficiaries under the plan, including qualified beneficiaries receiving continuation coverage under the plan under this paragraph.

(ii) *PAYMENTS.*—The plan may provide for payment of the total premium by the qualified beneficiary receiving such coverage, or for payment of all or part of such premium by the employer or other party and payment of the remainder of such premium by such beneficiary. The plan shall provide for payment of any premium by a qualified beneficiary in monthly installments if so elected by the beneficiary. If an election is made during an election period but after the termination

date, the plan shall permit payment of any premium for continuation coverage during the preceding period to be made within 45 days of the date of the election.

(iii) **PREMIUM DEFINED.**—As used in this subparagraph, the term “premium” means any amount payable with respect to the provision of coverage under a group health plan.

(F) **NOTICE REQUIREMENTS.**—In accordance with regulations of the Secretary—

(i) the group health plan must provide, at the time of commencement of coverage under the plan, for written notice to each covered employee and spouse of the employee (if any) of the rights provided under this paragraph;

(ii) the employer of a employee under the plan must notify the group health plan administrator if the employee dies;

(iii) each covered employee is responsible for notifying the group health plan administrator of the occurrence of any qualifying event (other than that described in subparagraph (C)(i)(I)) respecting that employee; and

(iv) the group health plan administrator must notify each qualified beneficiary, within a period of 14 days after the date the administrator is notified concerning the occurrence of a qualifying event affecting that beneficiary, of—

(I) the termination date with respect to the beneficiary, and

(II) the beneficiary’s right to elect continuation coverage under this paragraph and the election period established under subparagraph (B)(i) during which the beneficiary can exercise that right.

(G) **DEFINITIONS.**—For purposes of this paragraph—

(i) **COVERED EMPLOYEE.**—The term “covered employee” means an individual who is (or was) provided coverage under a group health plan by virtue of the individual’s employment or previous employment with an employer.

(ii) **QUALIFIED BENEFICIARY.**—The term qualified beneficiary means, with respect to a covered employee under a group health plan, any other individual who, on the date before the date of a qualifying event for that employee—

(I) is a beneficiary under the plan as the spouse of the employee and has been married to the employee for at least the immediately preceding 30-day period, or

(II) is a beneficiary under the plan as a covered dependent child of the employee.

(iii) **COVERED DEPENDENT CHILD.**—The term “covered dependent child” means, with respect to a covered employee, an individual who meets the generally applicable requirements of the plan for treatment as a depend-

ent child covered under the plan by reason of the coverage of the employee under the plan.

(iv) *GROUP HEALTH PLAN ADMINISTRATOR.*—The term “group health plan administrator” means, in connection with a group health plan, any person who provides for administrative functions relating to enrollment of individuals under the plan. For purposes of this subparagraph, the term “person” includes one or more individuals, governments or agencies of the United States or any State or political subdivision thereof, labor unions, partnerships, associations, corporations, legal representatives, mutual companies, joint ventures, joint stock companies, societies, trusts, unincorporated organizations, trustees, trustees in bankruptcy, receivers, and fiduciaries.

[(2)] (3) *GROUP HEALTH PLAN.*—For purposes of this subsection the term “group health plan” means any plan of, or contributed to by, an employer to provide medical care (as defined in section 213(d)) to his employees, former employees, or the families of such employees or former employees, directly or through insurance, reimbursement, or otherwise.

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CHAPTER 2—TAX ON SELF-EMPLOYMENT INCOME

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SEC. 1402. DEFINITIONS.

(a) *NET EARNINGS FROM SELF-EMPLOYMENT** * *

(b) *SELF-EMPLOYMENT INCOME.*—The term “self-employment income” means the net earnings from self-employment derived by an individual (other than nonresident alien individual, except as provided by an agreement under section 233 of the Social Security Act) during any taxable year; except that such term shall not include—

(1) that part of the net earnings from self-employment which is in excess of (i) an amount equal to the contribution and benefit base (as determined under section 230 of the Social Security Act) which is effective for the calendar year in which such taxable year begins, minus (ii) the amount of the wages paid to such individual during such taxable years; or

(2) the net earnings from self-employment, if such net earnings for the taxable year are less than \$400.

For purposes of clause (1), the term “wages” (A) includes such remuneration paid to an employee for services included under an agreement entered into pursuant to the provisions of section 218 of the Social Security Act (relating to coverage of State employees), or under an agreement entered into pursuant to the provisions of section 3121 (1) (relating to coverage of citizens of the United States who are employees of foreign affiliates of American employers), as would be wages under section 3121(a) if such services constituted employment under section 3121(b), (B) includes compensation

which is subject to the tax imposed by section 3201 or 3211, and (C) includes, but only with respect to the tax imposed by section 1401(b), remuneration paid for **[medicare qualified Federal employment (as defined in section 3121(u)(2))]** *medicare qualified government employment (as defined in section 3121(u) (3))* which is subject to the taxes imposed by section 3101(b) and 3111(b). An individual who is not a citizen of the United States but who is a resident of the Commonwealth of Puerto Rico, the Virgin Islands, Guam, or American Samoa shall not, for purposes of this chapter be considered to be a nonresident alien individual.

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Subtitle C—Employment Taxes and Collection of Income Tax at Source

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CHAPTER 21—FEDERAL INSURANCE CONTRIBUTIONS ACT

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Subchapter C—General Provisions

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Sec. 3125. Returns in the case of governmental employees in *States*, Guam, American Samoa, and the District of Columbia.

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SEC. 3121. DEFINITIONS.

(a) **WAGES.**—* * *

* * * * *

[(u) APPLICATION OF HOSPITAL INSURANCE TAX TO FEDERAL EMPLOYMENT.—

[(1) IN GENERAL.—For purposes of the taxes imposed by sections 3101(b) and 3111(b), subsection (b) shall be applied without regard to paragraph (5) thereof.

[(2) MEDICARE QUALIFIED FEDERAL EMPLOYMENT.—For purposes of this chapter, the term “medicare qualified Federal employment” means service which—

[(A) is employment (as defined in subsection (b)) with the application of paragraph (1), but

[(B) would not be employment (as so defined) without the application of paragraph (1).]

(u) APPLICATION OF HOSPITAL INSURANCE TAX TO FEDERAL, STATE, AND LOCAL EMPLOYMENT.—

(1) FEDERAL EMPLOYMENT.—*For purposes of the taxes imposed by sections 3101(b) and 3111(b), subsection (b) shall be applied without regard to paragraph (5) thereof.*

(2) STATE AND LOCAL EMPLOYMENT.—*For purposes of the taxes imposed by sections 3101(b) and 3111(b)—*

(A) *IN GENERAL.*—Except as provided in subparagraphs (B) and (C), subsection (b) shall be applied without regard to paragraph (7) thereof.

(B) *EXCEPTION FOR CERTAIN SERVICES.*—Service shall not be treated as employment by reason of subparagraph (A) if—

(i) the service is included under an agreement under section 218 of the Social Security Act, or

(ii) the service is performed—

(I) by an individual who is employed by a State or political subdivision thereof to relieve him from unemployment,

(II) in a hospital, home, or other institution by a patient or inmate thereof as an employee of a State or political subdivision thereof or of the District of Columbia,

(III) by an individual, as an employee of a State or political subdivision thereof or of the District of Columbia, serving on a temporary basis in case of fire, storm, snow, earthquake, flood or other similar emergency, or

(IV) by any individual as an employee included under section 5351(2) of title 5, United States Code (relating to certain interns, student nurses, and other student employees of hospitals of the District of Columbia Government), other than as a medical or dental intern or a medical or dental resident in training.

As used in this subparagraph, the terms “State” and “political subdivision” have the meanings given those terms in section 218(b) of the Social Security Act.

(C) *EXCEPTION FOR CURRENT EMPLOYMENT WHICH CONTINUES.*—Service performed for an employer shall not be treated as employment by reason of subparagraph (A) if—

(i) such service would be excluded from the term “employment” for purposes of this chapter if subparagraph (A) did not apply;

(ii) such service is performed by an individual—

(I) who was performing substantial and regular service for remuneration for that employer before January 1, 1986,

(II) who is a bona fide employee of that employer on December 31, 1985, and

(III) whose employment relationship with that employer was not entered into for purposes of meeting the requirements of this subparagraph; and

(iii) the employment relationship with that employer has not been terminated after December 31, 1985.

(D) *TREATMENT OF AGENCIES AND INSTRUMENTALITIES.*—For purposes of subparagraph (C), under regulations—

(i) All agencies and instrumentalities of a State (as defined in section 218(b) of the Social Security Act) or of the District of Columbia shall be treated as a single employer.

(ii) *All agencies and instrumentalities of a political subdivision of a State (as so defined) shall be treated as a single employer and shall not be treated as described in clause (i).*

(3) **MEDICARE QUALIFIED GOVERNMENT EMPLOYMENT.**—*For purposes of this chapter, the term "medicare qualified government employment" means service which—*

(A) is employment (as defined in subsection (b)) with the application of paragraphs (2) and (2), but

(B) would not be employment (as so defined) without the application of such paragraphs.

* * * * *

SEC. 3122. FEDERAL SERVICE.

In the case of the taxes imposed by this chapter with respect to service performed in the employ of the United States or in the employ of any instrumentality which is wholly owned by the United States, [including service which is medicare qualified Federal employment (as defined in section 3121(u)(2)),] *including such service which is medicare qualified government employment (as defined in section 3121(u)(3))*, including service, performed as a member of a uniformed service, to which the provisions of section 3121(m)(1) are applicable, and including service, performed as a volunteer or volunteer leader within the meaning of the Peace Corps Act, to which the provisions of section 3121(p) are applicable, the determination whether an individual has performed service which constitutes employment as defined in section 3121(b), the determination of the amount of remuneration for such service which constitutes wages as defined in section 3121(a), and the return and payment of the taxes imposed by this chapter, shall be made by the head of the Federal agency or instrumentality having the control of such service, or by such agents as such head may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to such service without regard to the contribution and benefit base limitation in section 3121(a)(1), and he shall not be required to obtain a refund of the tax paid under section 3111 on that part of the remuneration not included in wages by reason of section 3121(a)(1). Payments of the tax imposed under section 3111 with respect to service, performed by an individual as a member of a uniformed service, to which the provisions of section 3121(m)(1) are applicable, shall be made from appropriations available for the pay of members of such uniformed service. The provisions of this section shall be applicable in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Army and Air Force Exchange Service, Army and Air Force Motion Picture Service, Navy Exchanges, Marine Corps Exchanges, or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Defense, at installations of the Department of Defense for the comfort, pleasure, contentment, and mental and physical improvement of personnel of such Department; and for purposes of this section the Secretary of Defense shall be deemed to be the head of such instrumentality. The provisions of this section shall be applicable

also in the case of service performed by a civilian employee, not compensated from funds appropriated by the Congress, in the Coast Guard Exchanges or other activities, conducted by an instrumentality of the United States subject to the jurisdiction of the Secretary of Transportation, at installations of the Coast Guard for the comfort, pleasure, contentment, and mental and physical improvement of personnel of the Coast Guard; and for purposes of this section the Secretary of Transportation shall be deemed to be the head of such instrumentality.

SEC. 3125. RETURNS IN THE CASE OF GOVERNMENTAL EMPLOYEES IN STATES, GUAM, AMERICAN SAMOA, AND THE DISTRICT OF COLUMBIA.

(a) STATES.—Except as otherwise provided in this section, in the case of the taxes imposed by sections 3101(b) and 3111(b) with respect to service performed in the employ of a State or any political subdivision thereof (or any instrumentality of any one or more of the foregoing which is wholly owned thereby), the return and payment of such taxes may be made by the head of the agency or instrumentality having the control of such service, or by such agents as such head may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to the service of such individuals without regard to the contribution and benefit base limitation in section 3121(a)(1).

[(a)] (b) GUAM.—The return and payment of the taxes imposed by this chapter on the income of individuals who are officers or employees of the Government of Guam or any political subdivision thereof or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, and those imposed on such Government or political subdivision or instrumentality with respect to having such individuals in its employ, may be made by the Governor of Guam or by such agents as he may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to the service of such individuals without regard to the contribution and benefit base limitation in section 3121(a)(1).

[(b)] (c) AMERICAN SAMOA.—The return and payment of the taxes imposed by this chapter on the income of individuals who are officers or employees of the Government of American Samoa or any political subdivision thereof or of any instrumentality of any one or more of the foregoing which is wholly owned thereby, and those imposed on such Government or political subdivision or instrumentality with respect to having such individuals in its employ, may be made by the Governor of American Samoa or by such agents as he may designate. The person making such return may, for convenience of administration, make payments of the tax imposed under section 3111 with respect to service of such individuals without regard to the contribution and benefits base limitation in section 3121(a)(1).

[(c)] (d) DISTRICT OF COLUMBIA.—In the case of the taxes imposed by this chapter with respect to service performed in the employ of the District of Columbia or in the employ of any instrumentality which is wholly owned thereby, the return and payment of the taxes may be made by the Mayor of the District of Columbia

or such agents as he may designate. The person making such return may, for convenience of administration, make payments of the tax imposed by section 3111 with respect to such service without regard to the contribution and benefit base limitation in section 3121(a)(1).

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UNEMPLOYMENT REPAYMENT TAX

CHAPTER 23A—RAILROAD UNEMPLOYMENT REPAYMENT TAX

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SEC. 3321. IMPOSITION OF TAX.

(a) **GENERAL RULE.**—There is hereby imposed on every rail employer for each taxable period an excise tax, with respect to having individuals in his employ, equal to the applicable percentage of the total rail wages paid by him during the taxable period.

(b) **TAX ON EMPLOYEE REPRESENTATIVES.**—

(1) **IN GENERAL.**—There is hereby imposed on the income of each employee representative a tax equal to the applicable percentage of the rail wages paid to him during the taxable period.

(2) **DETERMINATION OF WAGES.**—The rail wages of an employee representative for purposes of paragraph (1) shall be determined in the same manner and with the same effect as if the employee organization by which employee representative is employed were a rail employer.

[(c) RATE OF TAX.—For purposes of this section—

[(1) FOR TAXABLE PERIOD JULY 1 THROUGH DECEMBER 31, 1986.—The applicable percentage for the taxable period beginning on July 1, 1986, and ending on December 31, 1986, shall be 2 percent.

[(2) SUBSEQUENT TAXABLE PERIODS.—The applicable percentage for any taxable period beginning after 1986 shall be the sum of—

[(A) 2 percent, plus

[(B) 0.3 percent for each preceding taxable period.

[In no event shall the applicable percentage exceed 5 percent.]

(c) RATE OF TAX.—For purposes of this section—

(1) IN GENERAL.—The applicable percentage for any taxable period shall be the sum of—

(A) the basic rate for such period, and

(B) the surtax rate (if any) for such period.

(2) BASIC RATE.—For purposes of paragraph (1)—

(A) FOR PERIODS BEFORE 1989.—The basic rate shall be—

(i) 4.3 percent for the taxable period beginning on July 1, 1986, and ending on December 31, 1986.

(ii) 4.7 percent for the 1987 taxable period, and

(iii) 6 percent for the 1988 taxable period.

who makes a return pursuant to section 3125 shall be deemed a separate employer.

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CHAPTER 65—ABATEMENTS, CREDITS, AND REFUNDS

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Subchapter B—Rules of Special Application

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SEC. 6413. SPECIAL RULES APPLICABLE TO CERTAIN EMPLOYMENT TAXES.

(a) ADJUSTMENT OF TAX.—

(1) **GENERAL RULE.**—If more than the correct amount of tax imposed by section 3101, 3111, 3201, 3221, or 3402 is paid with respect to any payment of remuneration, proper adjustments, with respect to both the tax and the amount to be deducted, shall be made, without interest, in such manner and at such times as the Secretary may by regulations prescribe.

(2) **UNITED STATES AS EMPLOYER.**—For purposes of this subsection, in the case of remuneration received from the United States or a wholly-owned instrumentality thereof during any calendar year, each head of a Federal agency or instrumentality who makes a return pursuant to section 3122 and each agent, designated by the head of a Federal agency or instrumentality, who makes a return pursuant to such section shall be deemed a separate employer.

(3) **GUAM OR AMERICAN SAMOA AS EMPLOYER.**—For purposes of this subsection, in the case of remuneration received during any calendar year from the Government of Guam, the Government of American Samoa, a political subdivision of either, or any instrumentality of any one or more of the foregoing which is wholly owned thereby, the Governor of Guam, the Governor of American Samoa, and each agent designated by either who makes a return pursuant to section 3125 shall be deemed a separate employer.

(4) **DISTRICT OF COLUMBIA AS EMPLOYER.**—For purposes of this subsection, in the case of remuneration received during any calendar year from the District of Columbia or any instrumentality which is wholly owned thereby, the Mayor of the District of Columbia and each agent designated by him who makes a return pursuant to section 3125 shall be deemed a separate employer.

(5) **STATES AND POLITICAL SUBDIVISIONS AS EMPLOYER.**—For purposes of this subsection, in the case of remuneration received from a State or any political subdivision thereof (or any instrumentality of any one or more of the foregoing which is wholly owned thereby) during any calendar year, each head of an agency or instrumentality

ty, and each agent designated by either, who makes a return pursuant to section 3125 shall be deemed a separate employer.

* * * * *

(c) SPECIAL REFUNDS.—

(1) IN GENERAL.—If by reason of an employee receiving wages from more than one employer during a calendar year the wages received by him during such year exceed the contribution and benefit base (as determined under section 230 of the Social Security Act) which is effective with respect to such year, the employee shall be entitled (subject to the provisions of section 31(b)) to a credit or refund of any amount of tax, with respect to such wages, imposed by section 3101 or section 3201, or by both such sections, and deducted from the employee's wages (whether or not paid to the Secretary), which exceeds the tax with respect to the amount of such wages received in such year which is equal to such contribution and benefit base. The term "wages" as used in this paragraph shall, for purposes of this paragraph, include "compensation" as defined in section 3231(e).

(2) APPLICABILITY IN CASE OF FEDERAL AND STATE EMPLOYEES, EMPLOYEES OF CERTAIN FOREIGN AFFILIATES, AND GOVERNMENTAL EMPLOYEES IN GUAM, AMERICAN SAMOA, AND THE DISTRICT OF COLUMBIA.—

(A) FEDERAL EMPLOYEES.—In the case of remuneration received from the United States or a wholly owned instrumentality thereof during any calendar year, each head of a Federal agency or instrumentality who makes a return pursuant to section 3122 and each agent, designated by the head of a Federal agency or instrumentality, who makes a return pursuant to such section shall, for purposes of this subsection, be deemed a separate employer, and the term "wages" includes, for purposes of this subsection, the amount, not to exceed an amount equal to the contribution and benefit base (as determined under section 230 of the Social Security Act) for any calendar year with respect to which such contribution and benefit base is effective, determined by each such head or agent as constituting wages paid to an employee.

(B) STATE EMPLOYEES.—For purposes of this subsection, in the case of remuneration received during any calendar year, the term "wages" includes such remuneration for services covered by an agreement made pursuant to section 218 of the Social Security Act as would be wages if such services constituted employment; the term "employer" includes a State or any political subdivision thereof, or any instrumentality of any one or more of the foregoing; the term "tax" or "tax imposed by section 3101" includes, in the case of services covered by shall apply whether or not any amount deducted from the employee's remuneration as a result of an agreement made pursuant to section 218 of the Social Security Act has been paid to the Secretary.

(C) **EMPLOYEES OF CERTAIN FOREIGN AFFILIATES.**—For purposes of paragraph (1) of this subsection, the term “wages” includes such remuneration for services covered by an agreement made pursuant to section 3121(1) as would be wages if such services constituted employment; the term “employer” includes any American employer which has entered into an agreement pursuant to section 3121(1); the term “tax” or “tax imposed by section 3101” includes, in the case of services covered by an agreement entered into pursuant to section 3121(1), an amount equivalent to the tax which would be imposed by section 3101, if such services constituted employment as defined in section 3121; and the provisions of paragraph (1) of this subsection shall apply whether or not any amount deducted from the employee’s remuneration as a result of the agreement entered into pursuant to section 3121(1) has been paid to the Secretary.

(D) **GOVERNMENTAL EMPLOYEES IN GUAM.**—In the case of remuneration received from the Government of Guam or any political subdivision thereof or from any instrumentality of any one or more of the foregoing which is wholly owned thereby during any calendar year, the Governor of Guam and each agent designated by him who makes a return pursuant to section [3125(a)] 3125(b) shall, for purposes of this subsection, be deemed a separate employer.

(E) **GOVERNMENTAL EMPLOYEES IN AMERICAN SAMOA.**—In the case of remuneration received from the Government of American Samoa or any political subdivision thereof or from any instrumentality of any one or more of the foregoing which is wholly owned thereby, during any calendar year, the Governor of American Samoa and each agent designated by him who makes a return pursuant to section [3125(b)] 3125(c) shall, for purposes of this subsection, be deemed a separate employer.

(F) **GOVERNMENTAL EMPLOYEES IN THE DISTRICT OF COLUMBIA.**—In the case of remuneration received from the District of Columbia or any instrumentality wholly owned thereby, during any calendar year, the Mayor of the District of Columbia and each agent designated by him who makes a return pursuant to section [3125(c)] 3125(d) shall, for purposes of this subsection, be deemed a separate employer.

(G) **EMPLOYEES OF STATES AND POLITICAL SUBDIVISIONS.**—*In the case of remuneration received from a State or any political subdivision thereof (or any instrumentality of any one or more of the foregoing which is wholly owned thereby) during any calendar year, each head of an agency or instrumentality, and each agent designated by either, who makes a return pursuant to section 3125(a) shall, for purposes of this subsection, be deemed a separate employer.*

(3) **APPLICABILITY WITH RESPECT TO COMPENSATION OF EMPLOYEES SUBJECT TO THE RAILROAD RETIREMENT TAX ACT.**—In the case of any individual who, during any calendar year, receives wages from one or more employers and also receives compensation

which is subject to the tax imposed by section 3201 or 3211, such compensation shall, solely for purposes of applying paragraph (1) with respect to the tax imposed by section 3101(b), be treated as wages received from an employer with respect to which the tax imposed by section 3101(b) was deducted.

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Subtitle I—Trust Fund Code

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CHAPTER 98—TRUST FUND CODE

* * * * *

Subchapter A—Establishment of Trust Funds

Sec. 9501. Black Lung Disability Trust Fund.

Sec. 9505. Tobacco Equalization Trust Fund.

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SEC. 9505. TOBACCO EQUALIZATION TRUST FUND.

(a) *CREATION OF TRUST FUND.*—There is established in the Treasury of the United States a trust fund to be known as the "Tobacco Equalization Trust Fund", consisting of such amounts as may be appropriated or credited to the Tobacco Equalization Trust Fund as provided in this section or section 9602(b).

(b) *TRANSFERS TO TOBACCO EQUALIZATION TRUST FUND.*—There is hereby appropriated to the Tobacco Equalization Trust Fund an amount to so much of the taxes received in the Treasury after September 30, 1985, and before October 1, 1990, under section 5701(b) (relating to tax on cigarettes) as is attributable to such tax determined at the rates of—

(1) 50 cents per thousand in the case of cigarettes taxable under section 5701(b)(1), and

(2) \$1.05 per thousand in the case of cigarettes taxable under section 5701(b)(2).

(c) *EXPENDITURES FROM TRUST FUND.*—Equalization Trust Fund shall be available, as provided in appropriation Acts, for the reimbursement of the Commodity Credit Corporation for part or all of the amount of any net realized losses sustained after September 30, 1985, by such Corporation under section 106, 106A, or 106B of the Agricultural Act of 1949 (or any successor tobacco support provision hereafter enacted) with respect to crop years of tobacco after 1981.

(2) *REPAYMENTS AND CREDITS.*—The Secretary shall pay from time to time from the Tobacco Equalization Trust Fund to the general fund of the Treasury amounts equivalent to the same proportion of the credits allowed, and refunds made, after September 30, 1985, and before October 1, 1990, with respect to the tax imposed by section 5701(b) as the portion the tax imposed by

V. DISSENTING AND ADDITIONAL DISSENTING VIEWS

A. DISSENTING VIEWS

We voted against reporting this bill. Although a \$19 billion reduction in the federal deficit over three years is certainly a significant accomplishment, we are troubled by a number of elements of this package and its legislative context.

One major flaw is that the bill includes increases in federal spending. It expands spending in existing programs, it creates a new program, and it continues a program scheduled to "sunset." This extra spending must be paid for through higher taxes or greater reductions in other programs. We believe that it would be far better to hold the line on all programs so that the total amount of spending cuts could be credited against the \$200 billion federal deficit.

For some of us, a second flaw is that the bill establishes a bad precedent by earmarking part of the excise tax on tobacco to pay, in effect, for the tobacco price support program. Some of us fear that this leads us down a path toward creation or expansion of special taxes, fees, and levies to facilitate the continued growth of federal domestic spending at a time when we should continue to cut back on spending at every possible turn. In addition, the failure to sunset this increase after the three-year budget period, as one of us proposed in an amendment, eliminates the necessity to review the appropriateness of this tax level.

Expanded spending on existing programs would occur under this bill in the Aid to Families with Dependent Children (AFDC) program. The program currently permits states the option to provide benefits to unemployed two-parent families. About half the states are using this option. The bill would require all states to pay welfare benefits to two-parent families at a three-year cost of more than \$400 million and a state cost of about two-thirds that amount, even though a dozen of those states have total unemployment rates less than the national average and low enough to make it likely that parents could find work readily. When the expanded program is fully implemented after 1989, it will cost around \$300 million each year in federal outlays, a figure masked by the lower start-up costs contained in the three-year 1986-1988 estimates.

A second AFDC spending increase involves relaxing the quality control program which was established under the 1979 "Michel amendment" to combat welfare fraud, waste and inefficiency. Federal refusal to pay for more than three percent of welfare payments made in error has resulted in steady reductions in state error rates, although in 1981 over \$1 billion still continued to be spent in excess of the amounts that properly should have been paid to recipients. Although the three-year estimate for easing up on the quality control program is \$70 million, more than \$200 million

a year in additional federal spending for "erroneous" welfare payments will be involved by Fiscal 1990 under this bill.

The bill creates a new \$150 million program of federal grants to states for programs to deal with teenage pregnancy through prevention, counseling and services. Teenage childbearing is a troubling and serious problem. However, we are doubtful that throwing federal funds at the situation is the answer. This time of high federal deficits is not the time to begin such a dubious experiment.

The bill also continues a program—Trade Adjustment Assistance (TAA)—that was scheduled to end on September 30, 1985. Even though the program has been spending \$100 million a year, it is listed by the Committee as having no cost for a three-year extension. This is possible because under House budget scoring procedures, continuation of a program does not count as additional spending, even though the program was scheduled to end. Despite the program's expansion to include workers and firms not previously covered and liberalization with regard to prior employment requirements, it is still listed as having no additional costs. In this case the reason is that we do not have the data to specify exactly what those costs will be. The Jobs Partnership Training Act provides the same job training the relocation allowances to displaced workers as will be continued under what could be argued is a duplicative TAA program. Under the current budget constraints, some of us feel we could do better with only one program, not two.

Notwithstanding these flaws, the bill makes a number of useful and justified deficit reductions. Most of us are generally in agreement with the amount of spending reduction allowed through the package of health amendments. The increase in customs personnel will improve customs efficiency, primarily in the commercial sector, while at the same time increasing customs revenues over the three years by \$1.150 billion. Similarly, the additional IRS positions will improve the processing of tax returns and will result in a three-year revenue increase of \$1.245 billion. The increase in premium paid by employers to the Pension Benefit Guaranty Corporation will begin to address the significant unfunded liability of the termination insurance program. Moreover, limiting the increase to only three years will help focus continued Congressional attention on the need for a comprehensive review of that program.

This legislation is ostensibly in the nature of a budget resolution bill. However, no budget resolution yet has been enacted for the upcoming fiscal year, so this bill therefore conforms, more or less, to the House-passed budget resolution. If House-Senate agreement is to be reached on a Congressional budget resolution, it will undoubtedly require further spending cuts beyond those originally proposed by the House. Thus, the speedy action to hurry this bill out of Committee seems premature to us. Necessary as these spending cuts and revenue increases may be, and despite the urgency of the federal deficit situation, we find that we can support neither the entire substance of this bill as it came out of our Committee nor the legislative context in which it was considered.

In situations such as this when dealing with many-faceted, multipurpose legislation, it is understandable that any sizable group of rational human beings will find absolute unanimity difficult, if not impossible, to achieve. In this particular case, the bill has at least a

little something we all can oppose. Some of us have stronger, or divergent, views on certain provisions of H.R. 3128. A few of us have elaborated on those differences in following, individualized statements. Others among us intend to express our supplemental thoughts in Floor remarks and in additional forums.

JOHN J. DUNCAN.
BILL ARCHER.
GUY VANDER JAGT.
PHILIP M. CRANE.
BILL FRENZEL.
RICHARD T. SCHULZE.
BILL GRADISON.
W. HENSON MOORE.
CARROLL A. CAMPBELL, Jr.
WILLIAM M. THOMAS.
HAL DAUB.
JUDD GREGG.

B. ADDITIONAL DISSENTING VIEWS

The Republican Members of the Committee on Ways and Means find it fiscally irresponsible to spend \$600 million in new money in a bill that is supposed to be a deficit reduction measure. This money is being spent generally to liberalize the welfare program without regard for work or training of the recipients.

We have serious reservations about amending the AFDC quality control system because we believe that the proposed legislative changes have not taken into consideration the slow progress that has been made towards efficient management of the program. We fear that the changes that have been made by the exclusion of so-called technical errors will result in a more costly program with fewer safeguards for avoidable paperwork mistakes.

Further, we have now moved to a mandated unemployed-parent program. Under current law, the program is a state option and it should remain a state option.

This bill also creates a program to provide comprehensive and preventive services to teenage parents. This two year grant program to permit the state AFDC agencies to operate a two-part teenage pregnancy program may offer solutions to a complicated and difficult problem, however, the creation of a new program in a deficit reduction bill seems misplaced.

Within the teenage pregnancy bill, it is clearly the intent of the Committee on Ways and Means to not allow abortions to be performed or to include the counseling of individuals to have abortions except where the life of the mother would be endangered if the fetus were carried to term.

We understand that language in the Majority report states the anti-abortion amendment does not apply to current practices in law or regulations of Title IV or any other Social Security Act programs or other federally funded health and public assistance programs. We are concerned that this language may encourage the referral of pregnant teenagers to agencies that do counsel abortion and that the language may cause a circumvention of the intent of the bill language.

The intent of the bill language clearly is to stop abortion and the counseling of abortions, not to encourage the use of programs that may allow or counsel abortions.

Therefore, the report language should not encourage the referral to agencies that may counsel abortions except where the life of the mother would be endangered if the fetus were carried to term.

CARROLL A., CAMPBELL, Jr.,

BILL ARCHER.

PHILIP M. CRANE.

HAL DAUB.

BILL GRADISON.

JOHN J. DUNCAN.

WILLIAM M. THOMAS.

JUDD GREGG.

D. ADDITIONAL DISSENTING VIEWS OF CONGRESSMAN GUY VANDER JAGT

Although I am generally in strong agreement with the Minority Views relative to Fiscal Year 1986 spending and revenue provisions, there are two important areas in which I have differing views.

First, I strongly oppose the extension of the physician fee freeze for nonparticipating physicians beyond the current 15-month freeze. This freeze creates an unnecessary additional differentiation between participating and nonparticipating physicians, and is an inappropriate signal to send to Medicare providers.

Secondly, I would like to express my support for the reauthorization of the Trade Adjustment Assistance program, particularly the Trade Adjustment Assistance program for firms. This program is a small, but necessary tool in our efforts to combat the huge trade deficits facing our country. The reauthorization of this modest program is the least that Congress can do to support the many firms and workers that are being harmed by the flood of imports entering our country.

GUY VANDER JAGT.

F. ADDITIONAL DISSENTING VIEWS OF BILL FRENZEL

H.R. 3128

The attached dissenting views which I have signed do not express with enough vigor my opposition to H.R. 3128.

This bill not only creates new welfare programs, raises spending, funds redundant or obsolete programs, and raises taxes. Much worse, it misses another opportunity to enact real, permanent spending reductions. Again, the Committee has been tested, and has failed.

Title I, on Medicare, is the section of wasted opportunities. Title II funds Trade Adjustment Assistance which duplicates existing job training services, and it also raises Customs' "user fees" about 300% to \$200 million. No matter how those fees are perfumed they are new taxes.

Title III, the welfare section, is where we find a whole new program, and much extra unnecessary spending. In Title IV, dealing with railroad unemployment, the Committee assessed another \$200 million in new taxes, and used it to finance extra welfare spending.

Title V, Revenue Provisions, contains the controversial cigarette tax extension. Majority Members diverted (read spent) 1¢ of the tax to tobacco producers. That's a \$200 million annual gift from the taxpayers to tobacco growers.

Altogether, the bill is best described as another lost chance to some real money. It should be defeated, and the Committee sent back to the drawing board to do better.

BILL FRENZEL.

G. ADDITIONAL DISSENTING VIEWS OF HON. W. HENSON MOORE

In 1983, we enacted the most significant medicare change since the beginning of the program in 1965. In one bold, and long overdue, stroke we changed the basis for the payment to hospitals from an inflationary cost-based system to a prospectively-determined rate of payment that rewards efficiency and economy. The response to that change has been beyond our most optimistic expectations. The 1983 legislation provided an orderly transition to a national payment rate to allow time for hospitals to curtail their past budget-busting behavior. This transition gives hospitals three years to move away from their hospital specific costs towards a fully phased-in national payment system in FY 87. Unfortunately, in my view, the Committee included a provision to delay the transition by maintaining the current 50% hospital specific/50% regional-national rate for another year.

We all heard the crises of woe last year when the system moved to the current 50/50 rate and efforts were made then for a one year freeze in the phase in. We defeated those efforts to stop the progress of the system. We should do so again this year. If we bow to the pressures of high cost hospitals now, we will merely be sending signals that they can continue to operate inefficiently. Those hospitals that are contributing most significantly to the escalation of the cost of health care will be back at our door step next year asking for yet another freeze or some sort of exception to the prospective payment system.

Last year when high cost hospitals asked Congress to not move forward with the prospective payments system they gave us tales of impending financial disaster in the industry. According to data from the American Hospital Association, total hospital expenses rose by only 4.5% in 1984 as compared with 10.2% in 1983, while cost per case growth declined nearly 3%, admissions declined by 3.7%, and the average length of stay dropped 4.3%. Notwithstanding the decrease utilization, revenue margins rose from 5.1% to 6.2% over the period, thereby providing the best bottom line the industry has had in over 20 years. Most importantly, these changes have occurred without any convincing evidence that the quality of care has suffered.

While there are many factors at play in this remarkable performance, most experts would agree that the new medicare prospective payment system was, and is, the driving force. To stop the implementation of the system at this point, even for only a year, will send signals to high cost hospitals that we are not serious about a market oriented system for containing health care cost. Instead, hospitals will have the incentive to drift it back toward their excessive and expensive old habits. We can't afford to let this happen.

I offer a compromise amendment in the Ways and Means Committee to allow the prospective payment system to still move forward, but at a slower pace. That amendment was defeated by only two votes. I am hopeful that we will have a second opportunity on the House floor.

My amendment would allow one additional year for the transition to phase-in. Under my amendment, in FY 86, hospital payments would be calculated on a 60% regional-national rate/40% hospital specific rate. In FY 87, the calculation would move forward to 80% regional-national/20% hospital specific, and in FY 88, the system would be fully phased in at 100% national rate. This amendment would give high cost hospitals an opportunity to further adjust to the positive cost pressures of the prospective payment system, while still sending signals that Congress is serious about containing health care costs.

Clearly, the prospective payment system is not without its faults, but rather than delay its implementation, we should endeavor to "fine tune" the system as we go along. In this regard the Committee is to be commended for approving an improved wage index as well as an adjustment for hospitals that serve a disproportionate share of low income patients. These adjustments will aid considerably in addressing the concerns being expressed by those who are calling for the transition delay.

I am convinced, however, that the Committee's action to maintain for another year the current 50/50 payment mix would erode the progress we have made in getting hospital costs under control. Accordingly, I must take strong exception to that action, and I intend to work for a floor amendment to allow the system to go forward next year at a 60% regional-national/40% hospital-specific rate. I encourage my colleagues to support this effort.

I am also sorely disappointed that the Committee did not use this opportunity to enact sound structural changes to secure the future of the medicare trust fund. By all informed accounts, the trust fund will not remain solvent through this century. We had a unique opportunity to enact comprehensive structural changes in physician reimbursement, capital cost payments and program operations and lost it.

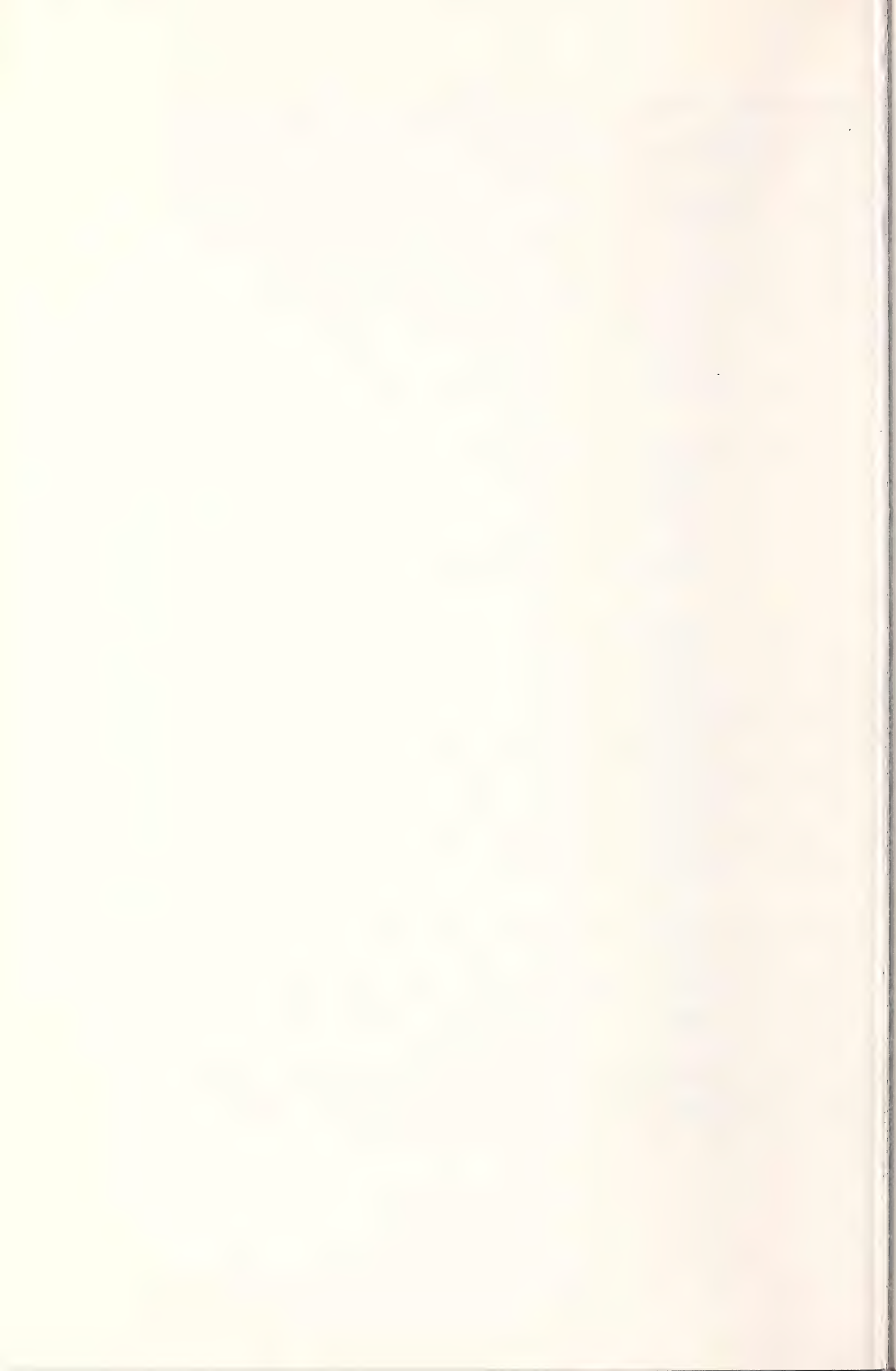
Instead the Committee chose the easy way out to achieve budget savings by singling out specific interests for one-time freezes or payment limitations and adding new taxes by including newly hired state and local employees under medicare. Of the \$10.3 billion in savings claimed from the health provisions, about 80% comes from temporary program changes such as freezes or limitations on hospital payments, physician payments, durable medical equipment and indirect medical education. Another 5% comes from the increased taxes. Less than 15% comes from permanent structural changes in payment policy. We have not made the permanent

programmatic changes needed to render medicare solvent. We will someday be forced to fight tougher political battles when we are at the brink of insolvency and have to take more drastic steps without the benefit of a long phase in period as we had available now.

I am most distressed that we have not taken advantage of this unique opportunity.

W. HENSON MOORE.





SINGLE-EMPLOYER PENSION PLAN TERMINATION INSURANCE PROVISIONS OF DEFICIT REDUCTION AMENDMENTS OF 1985

SEPTEMBER 11, 1985.—Ordered to be printed

Mr. HAWKINS, from the Committee on Education and Labor,
submitted the following

REPORT

[To accompany H.R. 3128]

[Including cost estimate and comparison of the Congressional Budget Office]

The Committee on Education and Labor, to whom was referred the bill (H.R. 3128) to make changes in spending and revenue provisions for purposes of deficit reduction and program improvement, consistent with the budget process, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment as reported by the Committee on Ways and Means) is as follows:

Page 153, strike out line 7 and all that follows down through line 3 on page 154 and insert in lieu thereof the following:

TITLE VI—SINGLE-EMPLOYER PLAN TERMINATION INSURANCE SYSTEM

SEC. 601. SHORT TITLE AND TABLE OF CONTENTS.

This title may be cited as "Single-Employer Pension Plan Amendments Act of 1985".

TABLE OF CONTENTS

- Sec. 601. Short title and table of contents.
- Sec. 602. Findings and declaration of policy.
- Sec. 603. Amendment of the Employee Retirement Income Security Act of 1974.
- Sec. 604. Definitions.
- Sec. 605. Increase in premium rates; revision of procedures for establishing premium rates; premium study.
- Sec. 606. Clarification of authority to freeze plans.
- Sec. 607. General requirements relating to termination of single-employer plans by plan administrator.
- Sec. 608. Standard termination of single-employer plans.
- Sec. 609. Distress termination of single-employer plans.
- Sec. 610. Termination proceedings; duties of the corporation.

No material re Social Security in this report.

SECTION 124 OF THE DEFICIT REDUCTION AMENDMENTS
OF 1985 (RESPONSIBILITY OF MEDICARE HOSPITALS IN
EMERGENCY CASES)

SEPTEMBER 11, 1985.—Ordered to be printed

Mr. RODINO, from the Committee on the Judiciary,
submitted the following

REPORT

[To accompany H.R. 3128]

[Including cost estimate of the Congressional Budget Office]

The Committee on the Judiciary, to whom was referred the bill (H.R. 3128) to make changes in spending and revenue provisions for purposes of deficit reduction and program improvement, consistent with the budget process, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment (stated in terms of the page and line numbers of the bill as reported by the Committee on Ways and Means) is as follows:

Page 33, strike line 14 and all that follows through page 42, line 6, and insert in lieu thereof the following:

SEC. 124. RESPONSIBILITIES OF MEDICARE HOSPITALS IN
EMERGENCY CASES.

(a) REQUIREMENT OF MEDICARE HOSPITAL PROVIDER
AGREEMENTS.—Section 1866(a)(1) of the Social Security Act
(42 U.S.C. 1395cc(a)(1)) is amended—

(1) by striking out “and” at the end of subparagraph
(G),

(2) by striking out the period at the end of subpara-
graph (H) and inserting in lieu thereof “, and”, and

(3) by inserting after subparagraph (H) the following
new subparagraph:

“(I) in the case of a hospital, to comply with the re-
quirements of section 1867 to the extent applicable.”.

(b) **REQUIREMENTS.**—Title XVIII of such Act is amended by inserting after section 1866 the following new section:

“EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN ACTIVE LABOR

“SEC. 1867. (a) MEDICAL SCREENING REQUIREMENT.—In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists or to determine if the individual is in active labor (within the meaning of subsection (e)(2)).

“(b) NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND ACTIVE LABOR.—If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either—

“(1) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, unless the examination or treatment is refused, or

“(2) for transfer of the patient to another medical facility in accordance with subsection (c).

“(c) RESTRICTING TRANSFERS UNTIL PATIENT STABILIZED.—

“(1) RULE.—If a patient at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(4)(B)) or is in active labor, the hospital may not transfer the patient unless—

“(A) a physician (within the meaning of section 1861(r)(1)) has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer, and

“(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

“(2) APPROPRIATE TRANSFER.—An appropriate transfer to a medical facility is a transfer—

“(A) in which the receiving facility—

"(i) has available space and qualified personnel for the treatment of the patient, and

"(ii) has agreed to accept transfer of the patient and to provide appropriate medical treatment, and

"(iii) is being provided appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring facility;

"(B) in which the transferring hospital provides the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital;

"(C) in which the transfer is effected through qualified personnel and transportation equipment, including the use of medically appropriate life support measures during the transfer; and

"(D) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of patients transferred.

"(d) ENFORCEMENT.—

"(1) AS REQUIREMENT OF MEDICARE PROVIDER AGREEMENT.—Failure of a hospital to meet the requirements of this section subjects the hospital to termination of its medicare provider agreement under this title, in accordance with section 1866(b).

"(2) CIVIL MONETARY PENALTIES.—In addition to the other grounds for imposition of a civil money penalty under section 1128A(a), a participating hospital that knowingly violates a requirement of this section and the responsible physician in the hospital with respect to such a violation are each subject, under that section, to a civil money penalty of not more than \$25,000 for each such violation. As used in the previous sentence, the term 'responsible physician' means, with respect to a hospital's violation of a requirement of this section, a physician who—

"(A) is employed by, or under contract with, the participating hospital, and

"(B) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.

"(3) CIVIL ENFORCEMENT.—Any individual who suffers personal harm and any medical facility which suffers a financial loss as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain damages and other appropriate relief. No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

"(e) DEFINITIONS.—In this section:

“(1) The term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

“(A) placing the patient’s health in serious jeopardy,

“(B) serious impairment to bodily functions, or

“(C) serious dysfunction of any bodily organ or part.

“(2) The term ‘active labor’ means labor at a time at which—

“(A) delivery is imminent,

“(B) there is inadequate time to effect safe transfer to another hospital, or

“(C) a transfer may pose a threat of the health and safety of the patient or the unborn child.

“(3) The term ‘participating hospital’ means hospital that has entered into a provider agreement under section 1866 and has, under the agreement, obligated itself to comply with the requirements of this section.

“(4)(A) The term ‘to stabilize’ means, with respect to a medical condition, to provide such medical treatment of the condition as may be necessary to assure that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

“(B) The term ‘stabilized’ means, with respect to a medical condition, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

“(5) The term ‘transfer’ means the movement (including the discharge) of a patient outside a hospital’s facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

“(f) PREEMPTION.—The provisions of this section do not preempt any State or local law requirement respecting hospitals, except to the extent that the requirement directly conflicts with a requirement of this section.”.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on October 1, 1985.

EXPLANATION OF COMMITTEE AMENDMENT

The Committee amendment clarifies the terms and scope of the new federal cause of action that would be established by § 124 of H.R. 3128. It also deletes the provision which would establish criminal penalties against responsible physicians who violate the requirements of § 124 and substitutes for these criminal penalties a new civil penalty of up to \$25,000 per violation. Finally, the amend-

ment makes technical and clarifying corrections to the language of the provision.

BACKGROUND

In recent years there has been a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured. Although at least 22 states have enacted statutes or issued regulations requiring the provision of limited medical services whenever an emergency situation exists,¹ and despite the fact that many state court rulings impose a common law duty on doctors and hospitals to provide necessary emergency care,² some are convinced that the problem needs to be addressed by federal sanctions.

As a result of this concern, the Ways and Means Committee reported § 124 of H.R. 3128 (new § 1867 of title 42). This section requires a hospital which has a Medicare Provider Agreement and which operates an emergency department to provide an appropriate medical screening of any individual for whom a request for treatment is made. The purpose of this screening is to determine if an emergency medical condition exists or if the patient is in active labor. If the hospital determines that either condition exists, the hospital must provide further treatment to stabilize the individual or, if it determines to transfer the individual to another facility, it must properly complete this transfer.

Although § 124 covers only hospitals with medicare agreements, its requirements apply to all individuals for whom care is sought, whether or not the individual is covered by Medicare.

Section 124, as reported by the Ways and Means Committee, contained four sanctions in the event a hospital or physician violates its requirements:

1. The termination of the hospital's medicare provider agreement.
2. The imposition of civil penalties against the hospital of up to \$25,000 per violation.
3. The establishment of a federal cause of action in the event of harm resulting from violation of its requirements.
4. As to the responsible physician, criminal penalties of not more than \$100,000 and/or not more than 1 year imprisonment—unless the patient dies as a result of transfer, in which case criminal penalties of not more than \$250,000 and/or not more than five years imprisonment.

JUDICIARY COMMITTEE AMENDMENTS TO SECTION 124

The Judiciary Committee focused its consideration of H.R. 3128 on the two enforcement provisions of § 124 that brought the provision within the jurisdiction of the Judiciary Committee: (1) the establishment of a new federal cause of action for violations of its requirements and (2) the establishment of criminal penalties for physicians who violate its requirements.

¹ "Emergency Room Statutes: A State-By-State Roundup" p. 485, Clearinghouse Review, vol. 18, No. 5, October 1984, p. 482.

² *Supra*, p. 490.

The Judiciary Committee shares the concern of the Ways and Means Committee that appropriate emergency room care be provided to patients faced with medical emergencies and in active labor. For this reason, the Judiciary Committee recommends that most of the provisions of § 124, as reported by the Ways and Means Committee, be adopted by the House.

However, the Judiciary Committee is also concerned that sanctions be designed to achieve the goal they address. There was little evidence available to the Committee during its consideration of H.R. 3128 as to the scope of the problem addressed by § 124, since there have been no hearings in either the House or the Senate on this issue or on the language recommended by the Ways and Means Committee. Thus, the Committee is concerned that if penalties are too severe, some hospitals, particularly those located in rural or poor areas, may decide to close their emergency rooms entirely rather than risk the civil fines, damage awards, and, as to physicians, criminal penalties that might ensue.

The Committee is also concerned that there was no information available to it regarding the potential impact of these enforcement provisions on the current medical malpractice crisis.

All of these considerations led the Committee to conclude that § 124 as reported by the Ways and Means Committee might result in a decrease in available emergency care, rather than an increase in such care, which appears to have been the major goal of the section. For all of these reasons, the Judiciary Committee has reported an amendment to the House that would strengthen and clarify the requirements of § 124 in three respects.

First, the Judiciary Committee amendment would extend the civil fines provision to the responsible physician, so that the physician, like the hospital, could be fined for violating the requirements of § 124 by up to \$25,000 per violation. The current provision allows this civil penalty to be assessed only against the hospital. The Committee believes the ability to assess this fine against the responsible physician as well as the hospital will be a strong incentive for both to respond to the medical needs of individuals with emergency medical conditions and women in active labor.

Second, the Judiciary Committee was concerned that the terms of § 124 which establish a new federal cause of action were somewhat vague. The language, as reported by the Ways and Means Committee, did not precisely identify which parties could bring actions under the provision, nor did it identify those against whom they could bring such action. The vagueness of the provision would not only leave the rights and liabilities of parties unclear, it also would place an unnecessary burden on the courts to define these rights and liabilities.

Therefore, the Committee amendment makes it clear that the section authorizes only two types of actions for damages. The first of these could be brought by the individual patient who suffers harm as a direct result of hospital's failure to appropriately screen, stabilize, or properly transfer that patient. The second type of action could be brought by a medical facility which received an improperly transferred emergency patient (within the meaning of § 124) or a woman in active labor. It also clarifies that actions for

damages may be brought only against the hospital which has violated the requirements of § 124.

This amendment requires that, in order to bring a civil action, the hospital must show it suffered a financial loss as a direct result of a participating hospital's violation of this requirement. It is sufficient, for purpose of this showing, that a public hospital which receives State or local funds to deliver care to the uninsured demonstrate only that it was required to commit any staff or other resources to the treatment of an individual transferred in violation of the requirement. The facility need not demonstrate an actual loss of revenues, net or gross.

This amendment also establishes a two-year statute of limitations for the filing of actions under this provision. Thus, any civil action for damages would have to be brought within two years of the incident which allegedly violated the requirements of § 124. The State Courts will have concurrent jurisdiction to hear and decide actions brought under this section.

Third, the Judiciary Committee amendment would delete that portion of § 124 which would impose criminal penalties on a physician who has professional responsibilities for the screening, examination, or treatment of a patient as required by the section. The Judiciary Committee understands and strongly supports holding physicians responsible for denying medical care. Indeed, it is for this reason that the Committee has recommended a provision in § 124 which would provide that a \$25,000 fine may be imposed on a physician, as well as a hospital, who fails to properly respond to the genuine medical needs of individuals who come to emergency rooms.

The Committee deleted the criminal sanction because, in the Committee's judgment, it is unnecessary, and unwise, and raises serious Constitutional questions under the due process clause.

The criminal sanction is unnecessary because the other sanctions in subsection (d) of proposed § 124 as amended by the Committee will serve to deter violations of the standards of proposed § 124. As noted above, § 124 as amended by the Committee, provides for three sanctions, and these sanctions may be imposed against both hospitals and doctors. Subsection (d)(1) authorizes stripping a hospital of its medicare certification whenever a hospital fails to meet the requirements of proposed § 124. Subsection (d)(2)—as amended—authorizes the imposition upon a hospital or doctor of a civil penalty of \$25,000 for each knowing violation of the requirements of proposed § 124. Finally, subsection (d)(3) authorizes an aggrieved party to sue a hospital, in federal or state court, for damages and other suitable relief. The principal purpose that a criminal sanction would serve in this area—deterrence of misconduct—is fully served by the sanctions of subsection (d) as amended by the Committee.

Moreover, the criminal sanction provision in the bill as reported by the Committee on Ways and Means raises serious questions of policy and Constitutionality. The criminal sanction provision holds doctors criminally liable for tort negligence. Thus, for example, a doctor is guilty of a crime for failing to provide treatment of a patient (when that failure represents a gross deviation from the prevailing local standards of medical practice), if the doctor had

reason to know (but did not in fact know) that a patient had an emergency medical condition.

This "reason to know" standard sets forth a civil law negligence standard. Liability for negligence is not unknown to the criminal law, but criminal negligence involves more than a mere failure to know; criminal negligence requires that the failure to know involve a gross deviation from a standard of reasonableness.³ Moreover, as a general proposition, a criminal negligence standard is used only rarely.⁴ Indeed, there is a body of opinion that holds that criminal sanctions should not apply to negligent conduct.⁵ The criminal sanction provision in subsection (d) as reported by the Committee on Ways and Means unwisely holds doctors criminally liable on a civil negligence standard, thereby making it possible to convict a doctor of a crime for a simple mistake.

Finally, the criminal sanction provision as reported by the Committee on Ways and Means has constitutional problems. That provision, as reported by the Committee on Ways and Means, makes a doctor criminally liable for failure to conduct an "appropriate" medical screening examination, if that failure constitutes a gross deviation from the "prevailing local standards of medical practice." Since the provision does not specify what is "appropriate" and what are the "prevailing local standards of medical practice," and since those terms may mean different things to different people, the provision raises serious questions under the void for vagueness doctrine.

The standards of certainty in statutes punishing for offenses is higher than in those depending primarily upon civil sanction for enforcement. The crime "must be defined with appropriate definiteness." There must be ascertainable standards of guilt. Men of common intelligence cannot be required to guess at the meaning of the enactment. The vagueness may be from uncertainty in regard to persons with the scope of the act, or in regard to the applicable tests to ascertain guilt.⁶

During its consideration of § 124, the Committee also considered an amendment which would have stricken both the new federal cause of action and the new criminal penalties and, instead, required the Secretary of the Department of Health and Human Services to conduct a study as to whether these two sanctions were needed. This amendment was defeated by a roll call vote of 16-18.

³ Thus, when this Committee drafted legislation to recodify federal criminal laws, it defined criminal negligence to be a failure to recognize a risk that a circumstance exists or a result will occur where the risk is of such a magnitude that the failure to perceive it constitutes a gross deviation from a standard of reasonable care. H.R. 6915, 96th Cong., 2d Sess. § 301(e) (1980). The Senate similarly defined criminal negligence in the bill it passed to recodify federal criminal laws. S. 1722, 96th Cong., 2d Sess. § 302(d) (1980).

See H.R. Rept. No. 1396, 96th Cong., 2d Sess. 34 (1980) ("Although the terms 'reckless' and 'negligent' are terms drawn from the civil law, their definitions in the proposed code are significantly different from civil law definitions."); Sen. Rep. No. 553, 96th Cong., 2d Sess. 65 (1980) ("... in requiring a 'gross deviation,' the standard for criminal negligence is stricter than that for ordinary tort negligence.").

⁴ This Committee, in the bill to recodify federal criminal law that it reported in the 96th Congress, did not use a criminal negligence standard in any of the offenses it defined.

⁵ See G. Williams, *Criminal Law: The General Part* 123 (2d ed. 1961); Hall, *Negligent Behavior Should Be Excluded From Penal Liability*, 63 Colum. L. Rev. 632 (1963).

⁶ *Winters v. New York*, 333 U.S. 507, 515-16 (1948) (citations and footnotes omitted).

RECOMMENDATION

The Judiciary Committee recommends that § 124, as amended by the Committee, be retained as a provision of H.R. 3128.

COMMITTEE VOTE

(Rule XI, clause 2(1)(2)(B))

On September 10, 1985, a quorum being present, the Committee on the Judiciary favorably reported by voice vote the portions of the bill H.R. 3128 which fall within the jurisdiction of the Committee with amendments.

OVERSIGHT STATEMENT

(Rule XI, clause 2(1)(3)(A))

The Committee on the Judiciary exercises its oversight responsibilities with reference to federal causes of action and criminal law and penalties. The Committee has determined that section 124 of H.R. 3128 should be favorably reported as amended.

BUDGET STATEMENT

(Rule XI, clause 2(1)(3)(B))

Section 124 of H.R. 3128 does not directly provide budget authority nor does it involve new or increased tax expenditures contemplated by clause 2(1)(3)(B) of Rule XI.

OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE ON GOVERNMENT OPERATIONS

(Rule XI, clause 2(1)(3)(D))

No findings or recommendations of the Committee on Government Operations were received as referred to in clause 2(1)(3)(D) of Rule XI on section 124 of H.R. 3128.

INFLATIONARY IMPACT

(Rule XI, clause 2(1)(4))

In compliance with clause 2(1)(4) of Rule XI, it is stated that the committee recommendations will have no inflationary impact on prices and costs in the operation of the national economy.

COSTS

(Rule XIII, clause 7(a)(1))

The costs are those outlined in the cost estimate of the Congressional Budget Office included in this report.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 11, 1985.

Hon. PETER W. RODINO, Jr.,
Chairman, Committee on the Judiciary,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed the amendment to H.R. 3128 as ordered reported by the Committee on the Judiciary. This amendment provides substitute language for certain enforcement and penalty provisions of Section 124 of H.R. 3128, the Deficit Reduction Amendments of 1985.

Based on this review, it is expected that no additional cost to the government will be incurred as a result of enactment of this amendment. Section 124 of H.R. 3128, as reported by the Committee on Ways and Means on July 31, 1985, establishes responsibilities of Medicare hospitals in emergency cases. The CBO expected that Section 124 would result in no additional cost to the government. This amendment changes only the enforcement and penalty provisions of Section 124. Therefore, no additional costs are incurred as a result of this amendment.

We would be pleased to respond to any questions you may have on this estimate. Your staff may contact Jack Rodgers (226-2820) with detailed questions.

With best wishes,
Sincerely,

ERIC HANUSHEK,
(For Rudolph G. Penner, Director).

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the portion of the bill referred to the Committee on the Judiciary are shown below. The differences between the bill as reported by the Committee and as reported by the Committee on Ways and Means are shown below using the following typographical devices (with "Judiciary" referring to the Committee on the Judiciary and "W&M" referring to the Committee on Ways and Means):

Existing Law—

- In which no change is proposed by Judiciary or W&M, printed in roman.
- Proposed to be omitted by both Judiciary and W&M, enclosed in black brackets, viz., [].

New Matter—

- Proposed to be inserted by both Judiciary and W&M, printed in *italic*.
- Proposed to be inserted only by W&M (and not by Judiciary), printed in italic linetype.
- Proposed to be inserted only by Judiciary (and not by W&M), printed in boldface roman.

SOCIAL SECURITY ACT

* * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * *

PART C—MISCELLANEOUS PROVISIONS

* * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * *

(G) in the case of hospitals which provide inpatient hospital services for which payment may be made under subsection (b) or (d) of section 1886, not to charge any individual or any other person for inpatient hospital services for which such individual would be entitled to have payment made under part A but for a denial or reduction of payments under section 1886(f)(2), [and]

(H) in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to have all items and services (other than physicians' services as defined in regulations for purposes of section 1862(a)(14)(i) that are furnished to an individual who is an inpatient of the hospital, and (ii) for which the individual is entitled to have payment made under this title, furnished by the hospital or otherwise under arrangements (as defined in section 1861(w)(1)) made by the hospital[.], and

(I) in the case of a hospital, to comply with the requirements of section 1867 to the extent applicable.

* * * * *

EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN ACTIVE LABOR

SEC. 1867. (a) *MEDICAL SCREENING REQUIREMENT.*—In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists or to determine if the individual is in active labor (within the meaning of subsection (e)(2)).

(b) *NECESSARY STABILIZING TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND ACTIVE LABOR.*—If any individual (whether or not eligible for benefits under this title) comes to the hospital and the individual is determined (through the screening described in subsection (a) or otherwise) to have an emergency medical condition or to be a hospital and the

hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either—

(1) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, unless the examination or treatment is refused, or

(2) for transfer of the patient to another medical facility in accordance with subsection (c).

(c) **RESTRICTING TRANSFERS UNTIL PATIENT STABILIZED.**—

(1) **RULE.**—If a patient at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(4)(B)) or is in active labor, the hospital may not transfer the patient unless—

(A) ~~there has been a written determination by a physician (within the meaning of section 1861(r)(1))~~ a physician (within the meaning of section 1861(r)(1)) has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the benefits ~~obtained~~ reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer, and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

(2) **APPROPRIATE TRANSFER.**—An appropriate transfer to a medical facility is a transfer—

(A) in which the receiving facility—

(i) has available space and qualified personnel for the treatment of the patient, and

(ii) has agreed to accept transfer of the patient and to provide appropriate medical treatment, and

(iii) is being provided appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring facility ; ;

(B) in which the transferring hospital provides the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital;

~~(B)~~ (C) in which the transfer is effected through qualified personnel and transportation equipment, including the use of medically appropriate life support measures during the transfer; and

~~(C)~~ (D) which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of patients transferred.

(d) **ENFORCEMENT.**—

(1) **AS REQUIREMENT OF MEDICARE PROVIDER AGREEMENT.**—Failure of a hospital to meet the requirements of this section subjects the hospital to termination of its medicare provider agreement under this title, in accordance with section 1866(b).

(2) **CIVIL MONETARY PENALTIES.**—In addition to the other grounds for imposition of a civil money penalty under section 11204(a), a participating hospital that knowingly violates a requirement of this section is

subject, under that section, to a civil money penalty of not more than \$25,000 for each such violation.

(2) **CIVIL MONETARY PENALTIES.**—In addition to the other grounds for imposition of a civil money penalty under section 1128A(a), a participating hospital that knowingly violates a requirement of this section and the responsible physician in the hospital with respect to such a violation are each subject, under that section, to a civil money penalty of not more than \$25,000 for each such violation. As used in the previous sentence, the term “responsible physician” means, with respect to a hospital’s violation of a requirement of this section, a physician who—

(A) is employed by, or under contract with, the participating hospital, and

(B) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.

(3) **CIVIL ENFORCEMENT.**—Any person or entity that is adversely affected directly by a participating hospital’s violation of a requirement of this section may bring an appropriate action, in an appropriate court of general jurisdiction of the State in which the hospital is located or in the appropriate Federal district court, for damages to the person arising from the violation and for such other equitable relief as may be appropriate to remedy the violation or deter subsequent violations.

(3) **CIVIL ENFORCEMENT.**—Any individual who suffers personal harm and any medical facility which suffers a financial loss as a direct result of a participating hospital’s violation of a requirement of this section may, in a civil action against the participating hospital, obtain damages and other appropriate relief. No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(4) **CRIMINAL PENALTIES.**—

(A) **IN GENERAL.**—A responsible physician (as defined in subparagraph (B)) who—

(i) has professional responsibilities for the provision of a screening examination of a patient in the hospital’s emergency department and either (I) knowingly fails to provide for any screening examination required under subsection (a) if the failure represents a gross deviation from the prevailing local standards of medical practice, or (II) provides for such a screening examination which is conducted in a manner that is so inappropriate as to represent a gross deviation from the prevailing local standards of medical practice, or

(ii) has professional responsibilities for the treatment of a patient, knows (or has reason to know) that the patient has an emergency medical condition or is in active labor, and who, within the staff and facilities available at the hospital, either (I) knowingly fails to carry out the individual’s responsibilities to provide for treatment of the patient under subsection (b) if the failure represents a gross deviation from the prevailing local standards of medical practice, or (II) provides for such treatment in a manner

that is so inappropriate as to represent a gross deviation from the prevailing local standards of medical practice; or

(iii) has professional responsibilities for the treatment of a patient; knows (or has reason to know) that either the patient has an emergency medical condition which has not been stabilized or the patient is in active labor; and either—

(I) knowingly transfers (or orders the transfer) of the patient other than to another medical facility; or

(II) knowingly transfers (or orders the transfer) of the patient to another medical facility; if the physician knows (or has reason to know) that the other facility does not have space available for the treatment of the patient and has not agreed to accept the patient;

shall be fined not more than \$100,000 or imprisoned not more than one year, or both; except that, if, as a direct result of the violation of this paragraph, the patient dies, the physician shall be fined not more than \$250,000 or imprisoned not more than five years, or both.

(B) **RESPONSIBLE PHYSICIAN DEFINED.**—As used in subparagraph (A), the term “responsible physician” means, with respect to a patient, a physician who—

(i) is employed by, or under contract with, a participating hospital; and

(ii) acting as such an employee or under such a contract, has professional responsibilities for the provision of examinations or treatments for the patient or transfers of the patient.

(e) **DEFINITIONS.**—In this section:

(1) The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(A) placing the patient’s health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(2) The term “active labor” means labor at a time at which—

(A) delivery is imminent,

(B) there is inadequate time to effect safe transfer to another hospital, or

(C) a transfer may pose a threat of the health and safety of the patient or the unborn child.

(3) The term “participating hospital” means hospital that has entered into a provider agreement under section 1866 and has, under the agreement, obligated itself to comply with the requirements of this section.

(4)(A) The term “to stabilize” means, with respect to a medical condition, to provide such medical treatment of the condition as may be necessary to assure that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

(B) The term “stabilized” means, with respect to a medical condition, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

(5) The term "transfer" means the movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(f) **PREEMPTION.**—The provisions of this section do not preempt any State or local law requirement respecting hospitals, except to the extent that the requirement directly conflicts with a requirement of this section.

The following documents were submitted to the Judiciary Committee regarding § 124 of H.R. 3128.

SUBMISSION BY THE LAW FIRM OF KENNY NACHWALTER & SEYMOUR

(The following letter was sent by the law firm of Kenny Nachwalter & Seymour to the Honorable Peter W. Rodino, Jr., on September 4, 1985.)

KENNY NACHWALTER & SEYMOUR,
Miami, FL, September 4, 1985.

Re: Deficit Reduction Amendments of 1985 (H.R. 3128)—Responsibilities of Medicare Hospitals in Emergency Cases.

Honorable PETER W. RODINO, Jr.,
Chairman, Committee on the Judiciary, House of Representatives,
2137 Rayburn House Office Building, Washington, DC.

DEAR MR. CHAIRMAN: I am writing in regard to Section 124 of the Medicare Reconciliation Amendments of 1985 (Title I of the Deficit Reduction Amendments of 1985 [H.R. 3128]) which sets forth certain responsibilities of Medicare hospitals with respect to the provision of emergency medical services.

The Deficit Reduction Amendments were reported out of the Committee on Ways and Means on July 31, 1985, and Section 124 was referred to the Committee on the Judiciary for its consideration before September 11, 1985.

We represent a number of health care providers and a large fiscal intermediary in the State of Florida, and our interest in this subject flows from our involvement with many of the legal and economic issues relating to the provision of medical services to the indigent, and more particularly, with the difficult questions often raised by the subject of patient transfers. I am not writing on behalf of any specific client, but I thought that our perspective from an operating vantage point in which we often deal with the day-to-day challenges faced by both hospitals and physicians in the treatment of indigent patients might be of some interest to you and to the other members of the Judiciary Committee.

Section 124 requires all Medicare provider hospitals, as a condition of participation, to provide an "appropriate" medical screening examination to any person who requests to be examined, and it expressly prohibits "inappropriate" patient transfers to other medical facilities. A responsible physician who violates the Section's requirements may be imprisoned for as much as one year and fined \$100,000, or, if a transferred patient dies as a result, the physician

may be sentenced to five years in prison and fined up to \$250,000. Civil penalties are also prescribed.

I am sympathetic to the concerns for patient safety which prompted the adoption of Section 124 by the Ways and Means Committee. I am concerned, however, that its enactment may signal a new and dramatic departure from the basic philosophical approach of the Medicare Act and that the practical operation of Section 124 may unavoidably result in some confusion and ambiguity and may lead to a degradation in the quality of American medical care and particularly in the availability of health care services to the poor.

During the twenty years since the enactment of Medicare, it has been the general philosophy of the federal government to refrain from interfering with medical decision-making by individual physicians and institutional providers or from limiting a beneficiary's freedom to choose among alternative sources of health care. These basic concepts have been incorporated into the Act itself at Sections 1801 and 1802 (42 U.S.C. §§ 1395 and 1395a), respectively.

To the best of my knowledge, Section 124, if enacted, will represent the first time that the federal government has attempted to regulate directly the manner in which medical services are provided. Section 124 seeks to prohibit inappropriate patient transfers and to require a medical screening examination for each patient who requests one. As laudable as these objectives are, however, their enforcement can only be obtained through the retrospective evaluation of intimate medical diagnostic and treatment decisions which have heretofore been left exclusively to the judgment of the physician and his patient. If section 124 becomes law, however, those decisions will be subject to the second opinion of federal prosecutors.

The enforcement of Section 124 will also be an extraordinarily complex task inasmuch as patients may be appropriately transferred to other facilities for a variety of legitimate reasons, not all of which are related to the patient's medical condition. A patient may be transferred because he or she belongs to a pre-paid health insurance plan or to a health maintenance organization which requires as a condition of coverage that the patient be hospitalized in a particular facility. A patient may be transferred because his or her personal physician is on the staff of a different hospital or because the patient has established a prior relationship with a particular health care provider. Sometimes patients request to be transferred because they are eligible for free medical care at a government hospital or at another public facility or because they wish to be treated at a location that is nearer to their residence, family and friends.

Individual decisions to transfer a patient often take place under the most difficult and time-sensitive circumstances. It may, for example, occasionally be the case that an emergency physician may redirect a patient to a different hospital on the basis of a brief examination when it is obvious that the transferring facility lacks the capability to provide for the patient's needs. The time required to examine the patient fully, complete a written determination that transfer is necessary and inform the receiving facility may literally mean the difference in some cases between life and death. At small or rural hospitals, a physician on call and away from the

hospital may be required to authorize the transfer of a patient based upon the initial evaluation of an attending nurse. Section 124 may ultimately force small hospitals to choose between either closing their emergency departments or hiring additional, fulltime medical personnel.

In addition, new modes of delivering emergency services have evolved during the past ten years which contemplate that patients will be routed to the nearest appropriate hospital, often on the basis of radio contact with rescue units or paramedics at the scene of an emergency. Regional trauma centers are specifically designed to direct patients among a number of different medical facilities so that patients may receive the best possible medical care as quickly as possible.

All of these developments and all of these possible transfer situations are entirely legitimate in the sense that the patient's ultimate welfare is thereby protected. Patient transfers take place for a wide variety of reasons, but Section 124 fails to take account of the fact that not all transfers are initiated for improper reasons. By sweeping all transfers into a single net, Section 124 may inadvertently penalize physicians who have actually served a patient's best interests by approving a transfer. It may encourage some emergency physicians to attempt procedures that they otherwise would not, and it may generally discourage transfers in all circumstances, even when motivated by a concern for the patient's best medical interests.

Section 124 is thus dangerously overbroad. Its enactment may contribute directly to a reduction in the quality of emergency medical services generally and indirectly to an increase in the overall costs of health care in the United States.

In addition to its overbreadth, important parts of Section 124 are extremely vague. It is not at all clear, for example, what is meant by "appropriate medical screening examination" as set forth in proposed Section 1867(a). If a patient is brought to a hospital suffering from a depressed skull fracture and the hospital has no neurological staff, is the examining physician nonetheless required to have the patient brought into the emergency department for an examination prior to the patient's transfer to an appropriate facility? Is a medical screening examination conducted by a nurse always "inappropriate"?

There is no guidance in Section 124 as to what satisfies the requirement of a written determination by a physician of the relative risks and benefits to the patient of a transfer to another medical facility as set forth in proposed Section 1867(c)(1)(A), and there is no indication of what purpose such a determination would serve. This requirement appears to constitute nothing more than an additional layer of regulatory paperwork, and it may result in a delay in treatment while the necessary forms are completed. More seriously, the language of Section 1867(c)(1)(A) would seem to prohibit any transfer of a patient until a physician can be summoned, a particular problem for hospitals which do not maintain full-service emergency departments.

I am particularly concerned by the requirement of proposed Section 1867(c)(2)(A)(ii) that the agreement of the receiving facility be obtained prior to transfer in all cases. We have encountered in-

stances in South Florida where administrative personnel at receiving hospitals have arbitrarily refused to accept patient transfers that have already been agreed to between the responsible physicians. This provision would effectively mean that any hospital could unilaterally bar all patient transfers, regardless of medical necessity. In addition, there are occasions in which a patient's condition may be so critical that an immediate transfer is indicated and notice to the receiving facility can only be given once the patient is actually on the way. Proposed Section 1867(c)(2)(A)(ii) would prohibit such urgent transfers in all circumstances.

At the very least, to the extent that certification requirements and criminal penalty provisions are incorporated into the final act, I would suggest that such provisions should be made reciprocal. Any receiving hospital should be required to document the fact, that it does not have available space or qualified personnel for the treatment of the patient, and criminal penalties should be imposed for the violation of this requirement.

Section 124 provides for the civil enforcement of its requirements at proposed Section 1867(d)(3) by "any person or entity that is adversely affected . . ." I assume that this provision was inserted to create a cause of action on behalf of receiving medical facilities, a remedy which may seriously aggravate relations among hospitals in particular localities, but it is at least arguable that it will also inspire claims by ambulance companies and rescue services and many even be interpreted to include, for example, an individual who may be struck by an ambulance carrying a patient from one hospital to another.

The same paragraph stipulates that an action to recover damages for a violation of Section 1867 may be brought "in an appropriate court of general jurisdiction of the State in which the hospital is located or in the appropriate Federal district court . . ." If this language is interpreted to create concurrent federal jurisdiction, the result will be a geometric increase in the number of garden-variety medical malpractice cases handled by the federal courts with all of the consequent burdens of time and expense for the federal judiciary.

Proposed Section 1867(d)(3) also contemplates the imposition of equitable relief to "deter subsequent violations." The standards under which injunctions are to be issued to restrain future violations of the Section are not spelled out, however, and this particular remedy would appear to be available to prevent future transfers of other patients not before the court. Inasmuch as patient transfer decisions are typically unique to the medical condition and personal circumstances of each patient, it should prove to be very difficult for the courts to frame appropriate orders and virtually impossible for them to monitor compliance. Because medical decision-making in any particular case is inherently a non-replicable type of activity, equitable sanctions would seem to be peculiarly inappropriate.

The primary test of physician criminal culpability spelled out in proposed Section 1867(d)(4)(A) is whether the physician's conduct represents "a gross deviation from the prevailing local standards of medical practice." To the best of my knowledge, this is a new formulation without any history of interpretation by the courts. In

Florida, for example, the "accepted standard of care for a given health care provider [is] that level of care, skill, and treatment which is recognized by a reasonably prudent similar health care provider as being acceptable under similar conditions and circumstances." Florida Statutes Section 768.45(1). How Section 124's definition will be applied in practice is unclear. It may turn out to be the case that juries will simply continue to award damages and will begin to convict physicians on the basis of their visceral sense of whether a patient has suffered any damage and how likely it is that civil penalties will ultimately be paid by malpractice insurers.

The availability of insurance coverage for violations of Section 124, however, is questionable. Most policies specifically exclude coverage for damages incurred as the result of criminal acts, and insurance in such circumstances may otherwise be prohibited as a matter of state public policy.

Proposed Section 1867(d)(4)(A)(iii) sets forth the Section's criminal penalties. It provides that a responsible physician may be imprisoned for up to five years and fined as much as \$250,000 "if, as a direct result of the violation of this paragraph, the patient dies . . ." It is at least conceivable that the heightened penalties may be invoked in some instances because of substandard medical care rendered at a receiving facility which results in a patient's death. The net effect may be to make physicians at the transferring facility insurers against medical malpractice committed by a different medical facility.

I further believe that most of the definitions contained in proposed Section 1867(e) are inadequate and will lead to unfortunate results in practice. Both the definitions of "emergency medical condition," and "active labor" are very liberal. They would each appear to include situations in which a patient's true medical condition could not reasonably be detected by an examining physician prior to transfer. Indeed, the definition of "active labor" set forth at proposed Section 1867(e)(2)(C) would seem to include women with high-risk pregnancies who might actually be several months away from their expected dates of delivery.

The terms "to stabilize" and "stabilized" set forth at proposed Section 1867(e)(4) stipulate that sufficient medical treatment must be rendered "to assure" that no material deterioration in the patient's condition will take place as the result of a transfer. This type of medical guarantee is ordinarily impossible to make in actual practice; sometimes patients must be moved to other facilities for medical reasons despite the fact that the patient's condition might deteriorate in transit.

I am also troubled by the sweeping inclusion in proposed Section 1867(e)(5) of "any person employed by (or affiliated or associated, directly or indirectly with)" a hospital among those capable of triggering liability. I am sure what this definition contributes to the Section other than to expand the potential circumstances under which liability may be imposed.

Finally, Section 124, by its terms, is scheduled to take effect on October 1, 1985. This is an extraordinarily rapid effective date and will undoubtedly result in the Section's application to physicians and hospitals who are completely unaware of the Section's existence.

With respect to the enforcement provisions set forth at proposed Section 1867(d), I am generally very skeptical as to wisdom of the civil enforcement and criminal penalties provided for at proposed Sections 1867(d)(3) and 1867(d)(4). It seems to me to be peculiarly inappropriate to use the Medicare Act as the vehicle for the introduction of new criminal sanctions against physicians, particularly when those sanctions can be invoked on behalf of patients who are not even eligible for Medicare benefits (as specified at proposed Sections 1867(a) and 1867(b)).

More fundamentally, there already exist a variety of sanctions for deterring and punishing improper physician conduct, including the authorization of inappropriate patient transfers. I need not belabor the impact of medical malpractice liability on physician decision-making. Suffice it to say that virtually all states now recognize a duty on the part of both physicians and hospitals to render emergency medical assistance to those in need who present at a hospital emergency department. Delaware was perhaps the first state to establish such a duty as a part of its common law. *Wilmington General Hospital v. Manlove*, 174 A.2d 135 (Del. 1961). Many states, including Florida, have expressly enacted such requirements by statute. The Florida statute provides, in pertinent part, as follows:

No general hospital licensed under this part, and no speciality hospital with an emergency room, shall deny any person treatment for an emergency medical condition which will deteriorate from a failure to provide such treatment. (Florida Statutes Section 395.0143.)

By imposing affirmative obligations to render emergency treatment to all patients, regardless of financial status, most states have already enacted the means for attaining Section 124's objectives.

The Committee should also bear in mind that most states require the revocation of a medical license upon conviction of a felony related to the practice of medicine. In Florida, such a requirement is incorporated at Florida Statutes Section 455.227(1)(c). Thus, the violation, purposeful or inadvertent, of Section 124 by a physician will almost always result in that physician's permanent removal from the profession.

I understand the concerns which motivated Section 124, and I believe that there are ways in which the section's objectives can be met. In particular, the review of patient transfer decisions as a matter of course should logically constitute one of the functions of the utilization and quality control peer review organizations established by Sections 1151 through 1163 of Title 11 (42 U.S.C. §§ 1320c-1320c-12).

Otherwise, I fear that Section 124 is overboard in its application, vague in its requirements and unnecessarily severe in its sanctions. I would hope that the Congress would chose to consider this important subject in a deliberate fashion and not attempt to enact prophylactic legislation in haste and without an opportunity for public comment.

I am grateful for your tolerance for the length of my comments, and I hope that they may prove useful to you and the other members of the Committee. If I can be of any other service on this matter, please do not hesitate to let me know.

With best regards.
Very truly yours,

PAUL M. BUNGE.

LETTER SUBMITTED BY THE AMERICAN COLLEGE OF EMERGENCY
PHYSICIANS

(This following letter was sent by the American College of Emergency Physicians to the Honorable Peter W. Rodino, Jr. on August 30, 1985.)

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS,
Dallas, TX, August 30, 1985.

HON. PETER W. RODINO, JR.,
*Chairman, Committee on the Judiciary, U.S. House of Representatives,
Rayburn House Office Building, Washington, DC.*

DEAR MR. CHAIRMAN: The House Medicare/Medicaid Budget Reconciliation package, H.R. 3128, as approved by the House Ways and Means Committee, includes Section 124 pertaining to responsibilities of Medicare hospitals in emergency cases. That section addresses all patient transfers, not just transfers of Medicare patients. The American College of Emergency Physicians shares the Committee's concerns and does not condone inappropriate patient transfers, some of which have recently come to light in the television and newspaper media. However, turning a few selected cases into federal criminal offenses does raise a number of problems. Section 124 of H.R. 3128 has been referred to the House Judiciary Committee until September 11.

American College of Emergency Physicians is a national medical specialty society that was founded in 1968 to further the discipline of emergency medicine. Since that time, our membership has grown to more than 11,000 physicians who practice their specialty in emergency facilities across the country. Each year, approximately 77 million visits are made to emergency facilities by patients who depend on emergency care providers to evaluate and treat their illnesses and injuries and to stabilize all life—and limb—threatening conditions. Emergency physicians must be available 24 hours a day, seven days a week to provide such unscheduled, episodic care.

From working in hospital emergency departments, emergency physicians have first-hand experience in providing emergency care and in dealing with the many factors in a patient transfer decision. We also are currently providing much of the medical care that indigent patients are receiving. Every day, we see price-competitive incentives being built into the health care system that work against the poor and medically indigent patient. All third-party payers, including Medicaid, insurers, and employers, are implementing cost saving measures, and they are succeeding. We are concerned about the effects on care for the poor and the near poor.

Although we are in agreement with the objective of the legislation (i.e., to eliminate inappropriate patient transfers), we believe the statutory language is excessively punitive to emergency physicians without truly addressing the patient transfer problem. The language as approved by the Ways and Means Committee is so intimidating to emergency physicians that transfers which are in the

best interest of patient care may be avoided or delayed. Because of the uncertain nature of the practice of emergency medicine and because of the retrospective standards of liability of this provision, emergency physicians may avoid transfers in order to protect themselves against criminal penalties and ultimate loss of their medical licenses because of the potential of felony convictions. Extreme caution could also result in prolonged detentions and unnecessary admissions. Neither is in the interest of patient care and both would increase health care costs.

Emergency physicians never know what types of cases will come into the emergency department. They must make rapid decisions regarding appropriate treatment, the need for hospitalization, and the type of consultation that may be needed. Time is often critical. The practice of emergency medicine is the challenge of making the best judgments under stressful conditions with limited information. This aspect also leaves the emergency physician most vulnerable to retrospective judgments as to what the physician "knows" (or has reason to "know") at the time multiple decisions are being made in the interest of emergency care. The course of a patient's injury or illness is often unpredictable. Yet, the definition of "stabilized" used in H.R. 3128 is not a medical (clinical) definition, but, rather, serves more as a warranty against "material deterioration of the condition." When is something "likely" to happen? In retrospect, if it did not happen, then it was not likely, but if something did happen in the course of time, then was it likely? Hindsight is always clearer than foresight.

Emergency physicians are central figures in the continuum of patient care. Emergency care begins in the prehospital setting, continues in the emergency facility, and concludes when the patient is discharged or when responsibility for the patient is transferred to another physician or facility. In most cases, emergency physicians do not have hospital admitting privileges and, therefore, are dependent upon hospitals and attending physicians to provide ongoing care to patients beyond the capacity of the emergency department. Only in very limited situations do emergency physicians provide inpatient services.

As central figures in the continuum of patient care, emergency physicians have become acutely aware of the patient transfer issue, as well as the more global problem of funding for indigent care. Insurers, employers, governments, physicians, and hospitals are all affected by this problem. The American College of Emergency Physicians has been and will continue to be committed to providing emergency care to indigent patients. ACEP has long held to the principle that all patients are entitled to emergency care, regardless of their ability to pay. We agree that all patients are entitled to have medical screening and stabilization. The College has established transfer guidelines which were recently expanded and updated, and we feel transfers are appropriate if they adhere to these guidelines. A copy of ACEP's patient transfer guidelines is attached. However, we as individual physicians cannot be held responsible for more than we can reasonably be expected to assure.

The conduct the proposed legislation is attempting to address is more appropriately governed by medical malpractice laws. Defensive medicine and medical malpractice are already recognized as

major problems. Expanding the jurisdiction over malpractice claims into federal courts, as this bill does, will exacerbate the current medical malpractice crisis. Reprehensible as true malpractice may be, we feel it is unfair to single out emergency physicians for federal criminal penalties while allowing states to address all other forms of malpractice. We also feel strongly that the proposed approach is an intrusion into areas properly left to the states, namely standards of medical practice.

We note that Medicare started with paying medical bills for the elderly. The proposed provision brings us to the point of federal standards of medical care for the non-elderly backed by criminal penalties. This bill is also precedent-setting in that it attempts to set standards for non-Medicare patients.

Under the proposed legislation, criminal penalties are being imposed in haste as part of a budget reconciliation process when the provisions is not a monetary item. The patient transfer provision was approved by the House Ways and Means Committee without hearings. If the intent of this legislation is to incorporate emergency care into Medicare participation criteria, the penalties should reflect already-existing sanctions within the Medicare Conditions of Participation for Hospitals. We believe hospital administrations, hospital governing boards, and hospital medical staffs should jointly develop plans that demonstrate how hospitals will handle patient transfer cases. Hospitals should be responsible for providing medical screening and stabilization, as defined medically, to all emergency patients who present for treatment. All hospitals should demonstrate they have established provisions for care by members of the medical staff for any patients who need admission, particularly when they are not eligible for transfer within the guidelines. All hospitals should also demonstrate they have established adequate disciplinary actions for violations of the transfer guidelines by members of the medical staff.

Because we feel the proposed legislation is extremely vague, and appears to be open to numerous interpretations, the American College of Emergency Physicians asks that time be taken to formulate a solution that will result in optimal patient care in these potential transfer situations. We are more than willing to work with you in developing alternative solutions and offer our assistance, and that of Virginia Pitcher, Director of the College's Washington Office, in addressing the patient transfer issue. Ms. Pitcher may be contacted at 2000 L Street, NW., Suite 200, Washington, DC 20036, telephone 202/861-0979.

Sincerely,

BRUCE D. JANIAK, MD, FACEP, *President.*

Enclosure.

THE EMERGENCY PHYSICIAN AND INDIGENT CARE

Emergency medicine is a distinct medical specialty, with approximately 15,000 physicians treating more than 77 million patients annually. It was recognized as the 23rd medical specialty by the American Board of Medical Specialties in 1979, and the first board certification examination was administered in 1980.

Today, 66 residency training programs in emergency medicine have graduated more than 1,500 physicians, with an additional 1,300 in training. More than 3,000 physicians are board certified in emergency medicine. The American College of Emergency Physicians, founded in 1968, is the medical specialty society representing more than 11,000 emergency physicians.

Emergency physicians practice full-time in hospital emergency departments throughout the country. Their practice is unique because they treat a wide range of medical conditions, from the victims of automobile or industrial accidents to children who have swallowed household detergent. Emergency physicians also must recognize and treat cases of child abuse and rape, in addition to working with burn victims, hypothermia victims, and patients suffering potentially deadly allergic reactions.

The emergency department often serves as an access point for patients entering the overall health care system. Emergency physicians serve as a conduit and evaluate, stabilize, and treat all patients who present to the emergency department. Inpatient treatment is almost always the responsibility of other specialists. Because most emergency physicians do not have admitting privileges to the hospital, their role ends when the patient is discharged or responsibility for the patient is transferred to the admitting physician or another facility.

Because they serve as the access point to the health care system, particularly for those who have no personal physician, emergency physicians are acutely aware of the indigent population in America. Because the indigent population frequently has nowhere to turn for medical care except the emergency department, emergency physicians frequently treat indigent patients.

The reality of this situation was reflected in recent research conducted by Medical Economics. According to the March 5, 1985, issue of Medical Economics, emergency physicians' median net practice earnings are 8% less than the median for all medical specialists. The magazine states the "principal explanation is that a high proportion of emergency department patients either can't or won't pay, while medical ethics and the policy of most hospitals require that they be treated." Most states also have statutes or regulations requiring that patients who present to hospital emergency departments be seen without regard to their ability to pay.

The Medical Economics survey of physicians showed that the typical emergency physician in 1983 rendered more than \$25,000 in uncompensated care, compared to approximately \$17,000 in uncompensated care provided by all physicians surveyed. The Medical Economics data indicate emergency physicians as a specialty provided more than \$380 million in uncompensated care in 1983. Emergency physicians accept uncompensated care as part of their practice because their overriding concern is the patient's welfare.

Frequently, patients are transferred to other facilities following evaluation and stabilization. Transfers occur in all economic strata for any number of reasons. There are often important considerations that may justify a transfer in individual cases that are not strictly related to the availability or suitability of post-emergency medical care in the transferring facility. Some of these considerations include:

An established medical relationship may exist between the patient and the receiving facility, including a history of prior admissions for other or related complaints;

The patient's personal physician may have attending privileges at the receiving facility and not at the transferring facility;

The patient's prior medical records may be on file at the receiving facility;

The patient may prefer to receive post-emergency medical care at a different hospital;

The patient's family, relatives and friends may be inconvenienced by admission of the patient to the transferring facility because of the distance between that facility and the patient's residence; and

The availability of free medical care at a public or government-financed medical facility may obviate or reduce the economic burdens that the patient might otherwise incur.

According to the American College of Emergency Physicians Patient Transfer Guidelines, the emergency physician's role in patient transfers is to stabilize the patient and establish medical responsibility for the patient with a physician at the receiving hospital before a transfer begins. Emergency physicians will make every effort to make the patient as comfortable as possible before the transfer begins. However, patients cannot always be pain-free before transfer because the pain may be a primary symptom needed to help the receiving physician diagnose and treat the patient.

Emergency physicians believe indigent health care is a crucial issue facing the country today. Transfer of patients is only one facet of this difficult problem. We, as a society, need to address all aspects of indigent health care, particularly the most significant element of the issue—the funding of indigent care. Emergency physicians will continue to staff emergency departments throughout the country and provide medical care to every patient who presents, regardless of their ability to pay.

POLICY STATEMENT ON TRANSFER OF PATIENTS ¹

From time to time, patients in an Emergency Department are transferred to other facilities. The transfer may be to another Emergency Department or directly to an inpatient facility. Clearly, not all physicians or medical facilities have the capabilities to care for every patient. At times, patients, or those responsible for them, request transfer to another facility for various reasons (which may or may not be medical); at times patients are transferred to receive the benefit of more appropriate facilities and/or services than are available in the given hospital or Emergency Department; and at times patients are transferred because of economic consideration, which may include the availability of free or reduced-cost medical care at a public or other facility or in accordance with the requirements of pre-existing contracts for patients of

¹ Approved by the ACEP Board of Directors on August 13, 1985. These are guidelines and are not to be construed as standards of care.

prepaid health plans that stipulate which facilities patients are to use.

Patients should not be transferred to another facility without first being stabilized. Stabilization includes adequate evaluation and initiation of treatment to assure the transfer of a patient will not, within reasonable medical probability, result in death, or loss or serious impairment of bodily parts or organs.

Stabilization of patients prior to transfer should include:

1. Establishing and assuring an adequate airway and adequate ventilation.

2. Initiating control of hemorrhage.

3. Stabilizing and splinting the spine or fractures when indicated.

4. Establishing and maintaining adequate access routes for fluid administration.

5. Initiating adequate fluid and/or blood replacement.

6. Determining that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion. The vital signs should remain within these parameters for a sufficient time prior to transfer to be reasonably certain they will not deteriorate while en route to the receiving hospital. However, there may be times when stabilization of a patient's vital signs is not possible because the hospital or Emergency Department does not have the appropriate personnel or equipment needed to correct the underlying process (e.g., thoracic surgeon on staff or cardiopulmonary bypass capability). In these cases, numbers 1-5 of the above should be performed and transfer carried out as quickly as possible.

At times, a patient or those responsible for the patient, may request a transfer that seems medically inappropriate. The physician is obliged to explain the medical risks involved, and an informed consent should be signed by the patient (or those responsible for the patient such as a parent or guardian) and the physician. In the event of such a transfer, the physician should still use every resource available in an attempt to stabilize the patient prior to transfer.

The following guidelines should be observed for transfer of patients:

1. The patient should be transferred to a facility appropriate to the medical needs of the patient. The facility should have adequate space and personnel available to care for the patient.

2. A physician or other responsible person at the receiving hospital must agree to accept the patient transfer prior to the transfer taking place. Acceptable "other responsible persons" should be medical personnel who are designated by the hospital and given the authority to accept the transfer of the patient. The patient transfer should not be refused by the receiving hospital when the transfer is indicated and the receiving hospital has the capability and/or responsibility to provide care to the patient.

3. Communication between responsible persons at the transferring and receiving hospitals for purposes of exchanging clinical information should occur prior to transfer. Ideally, this communication should be physician-to-physician.

4. Once a patient is accepted for transfer, an appropriate medical summary and other records (including lab results and copies of EKGs and X-rays) should be sent with the patient.

5. A patient should be transferred via a vehicle that has appropriately trained personnel and life-support equipment. At times, it may be necessary for additional specialized personnel from the transferring or receiving hospital to accompany the patient.

At times, transfer of patients occurs routinely or is part of a regionalized plan for obtaining optimal care for patients at more appropriate and/or specialized facilities. In these situations there should be:

1. Written guidelines (e.g., types of cases appropriate for transfer) to govern the transfer of patients;

2. Pre-existing transfer agreements between the facilities, and;

3. Pre-transfer communication between appropriate responsible personnel.

STATEMENT SUBMITTED BY THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

(The following statement was sent by the American College of Emergency Physicians to the House Judiciary Committee on September 6, 1985.)

STATEMENT

The American College of Emergency Physicians (ACEP) is a national medical specialty society that was founded in 1968 to further the discipline of emergency medicine. ACEP's membership now includes more than 11,000 emergency physicians who practice their specialty in emergency facilities throughout the United States. Each year, more than 77 million visits are made to emergency facilities by patients who depend upon the specialized training and expertise of emergency care providers to stabilize and treat virtually every type of serious illness and injury. Emergency physicians constitute the front-line of American medicine and, in many instances, they are effectively the only outpatient health care providers to a substantial portion of the nation's poorest citizens.

The United States Congress is currently considering the enactment of legislation which would regulate the provision of emergency medical services on a national basis. Section 124 of the Medicare Budget Reconciliation Amendments of 1985 (Title I of the Deficit Reduction Amendments of 1985 [H.R. 3128]) sets forth certain requirements and procedures to be followed by Medicare provider hospitals with respect to the provision of emergency medical treatment and imposes criminal penalties for the knowing violation of the section's requirements.

In general, ACEP believes that the objectives of Section 124 (proposed section 1867 of Title XVIII) in attempting to prevent the arbitrary transfer of patients who may suffer serious medical consequences as a direct result are laudable. There can be no question but that the health and safety of each patient is of paramount importance and that no patient should be denied access to emergency medical treatment simply because he or she may lack the ability to pay. ACEP has consistently emphasized the responsibility of all

physicians to adhere to the highest standards of medical care and ethics and to contribute to the health care needs of the medically indigent. Emergency physicians in particular have discharged their obligations in this regard with the utmost attention to the professional standards of their discipline and the public interest.

ACEP is very concerned, however, with the means proposed by Section 1867 for discouraging inappropriate transfers and most particularly with the criminal sanction provisions set forth at Section 1867(d)(4). In general, Section 1867 provides insufficient guidance to physicians and other responsible medical personnel as to their duties and obligations under the law, and its enactment may unintentionally result in the imposition of harsh criminal penalties on physicians who have fully conformed to the highest standards of medical ethics in the treatment of patients with emergency medical conditions. In addition, ACEP believes that the practical effect of the law's application may be actually to reduce the quality and availability of medical services to the poor and to raise health care costs generally, results which were not in the contemplation of Section 1867's sponsors.

As a consequence, ACEP believes that the enactment of Section 1867 as currently formulated would be highly inadvisable. ACEP's specific concerns with this legislation can be grouped into the following categories:

1. The subject of inappropriate patient transfers can best be dealt with as a part of the larger issue of indigent health care generally. Patient transfers are only one aspect of this overall problem which deserves the attention and consideration of the Congress.
2. A variety of effective mechanisms already exist for discouraging transfers which may endanger a patient's health or well-being, and the civil and criminal sanctions embodied in Section 1867 are therefore largely redundant.
3. In practice, the implementation of Section 1867's requirements may lead to a host of interpretive difficulties which may result in its unfair application in individual instances and in a general degradation of medical practice and emergency health care.
4. Acceptable and effective alternative solutions exist which could reduce the incidence of inappropriate patient transfers while preserving the independence and professional integrity of the treating physician.

It is not ACEP's position that appropriate legislation cannot be formulated to deal with some of the problems associated with patient transfers. ACEP believes, however, that the subject is a complex one, that its nature and dimensions vary widely among localities and that a comprehensive solution cannot be arrived at in isolation without addressing the broader issues of indigent health care and its overall financial requirements.

1. *Indigent Health Care.*—No one understands the full dimensions of indigent health care needs in the United States or the degree to which those needs are being met. There are no comprehensive data on the subject and only fragmentary analysis of the impact of indigent medical care requirements in specific communities.

We do know, however, that recent changes in the health care industry have probably affected the delivery of medical services to

the poor in an adverse fashion. The rapid introduction of competitive forces into the delivery of health services during the past few years has made it increasingly difficult for the private sector to absorb the costs of uncompensated care. Most notably, the implementation of the Prospective Payment System for Medicare reimbursement has exerted significant downward pressures on all hospital charges, eliminating the margin that used to be available for other purposes including the financing of indigent health care.

In addition, both consumers and third-party payors throughout the United States have become increasingly cost-conscious, and organized health care coalitions and new forms of group medical coverage such as preferred provider organizations and HMOs have reduced hospital utilization rates and cut average patient lengths of stay.

There is also a decreasing emphasis upon the provision of inpatient hospital services generally. Alternative health care delivery systems such as ambulatory surgical centers, freestanding emergency facilities and outpatient services of every sort have served to reduce hospital operating revenues and further limit the resources available for treatment of the poor.

The net effect of these developments has been to raise serious challenges to the continued financial viability of many hospitals. Some have already been forced to close; others can be expected to do so in the coming years. The impact in terms of indigent health care has been to make it even more difficult for the private sector to absorb the costs of uncompensated medical services. Despite this fact, America's community hospitals have continued to contribute their fair share: it has been estimated that the value of uncompensated hospital services rendered to the poor exceeds \$6 billion annually.

It is within the context of these sweeping changes in the health care industry that the issue of patient transfers must be considered. Realistically, the economic pressures generated by new competitive forces have increased the incentives to transfer patients to publicly-supported facilities where those patients may be eligible to receive free or reduced-cost medical care that is subsidized by tax revenues. Many private hospitals no longer have the option of admitting stabilized indigent patients to their facilities in every instance inasmuch as the fiscal stability of most hospitals has been undermined without providing an alternative source of funding for indigent health care costs.

Indeed, many public hospitals throughout the United States readily acknowledge the public nature of their responsibilities and accept indigent patients from private institutions as a matter of course. The overall prevalence and impact of indigent patient transfers from private institutions, however, is unknown. Much attention has recently been focused upon the anecdotal experiences of a few large public hospitals in major cities where it may well be the case that transfers are becoming a serious problem. There is reason to believe, however, that the nationwide incidence of inappropriate transfers is relatively slight and that many public hospitals are entirely able to accommodate patient transfers with no serious repercussions.

It is important to note, in this context, that an individual patient may be safely and appropriately transferred for a variety of reasons, not all of which are related to that patient's medical needs. It is not unusual for patients to be transported over long distances (occasionally across continents) with no perceptible risk to the patient involved. Patients may request to be transferred because they belong to pre-paid health plans which require their hospitalization in certain designated institutions. Patients may prefer to be hospitalized in a facility with which they have established a pre-existing relationship, because their personal physicians or medical records may be located at a different hospital, or because they simply wish to avoid the inconvenience and expense of an extended stay at a facility which is inconvenient or distant from their residence, family or friends.

In this regard, a patient's concern with the avoidance of debt likely to be incurred as a result of hospitalization at a private facility should not be discounted. While a patient's desire to seek admission to a public hospital may be motivated by economic concerns, ACEP believes that such a decision can be a legitimate one when free medical services are available and that the patient's preferences in this regard should be respected. Indeed, no medical facility can purport to retain a patient contrary to that patient's expressed intention to refuse treatment and seek admission elsewhere. In such a circumstance, a medical facility has no choice but to assist the patient in arranging a safe transfer once it is clear that the patient's condition will not be adversely affected as a result.

The central point is that the subject of patient transfers is a subtle and complex issue whose full dimensions are not clearly understood. It is not a topic which is susceptible to quick and universal solution. ACEP is concerned, however, that Section 1867, by mandating a nationwide regime of transfer standards enforced with criminal penalties, may inadvertently result in the exacerbation of the very situation it seeks to remedy.

In particular, ACEP fears that the enactment of Section 1867 may serve to discourage patient transfers under almost all circumstances. Faced with the prospect of substantial fines and possible imprisonment, many physicians may be understandably reluctant to authorize a transfer even when there may be a medical justification or when the patient has specifically requested to be transferred. The incentives to practice "defensive medicine" will become all the more compelling with the threat of criminal sanctions, and the consequent impact on health care costs generally may be unfortunate.

ACEP would consider such a development to be inconsistent with the standards of medical care and ethics and the goal of efficient health care delivery that it supports. This is particularly true inasmuch as ACEP believes that there are already existing mechanisms which strongly discourage inappropriate patient transfers in almost all cases.

2. Existing Disincentives to Inappropriate Patient Transfers.—ACEP is troubled by the implicit assumption of Section 1867 that severe criminal penalties are necessary to prevent physicians from arbitrarily transferring seriously ill and injured indigent patients

to public facilities. There is no dispute that occasionally such transfers do take place, but ACEP suspects that their incidence may have been overstated in the popular media. By and large, the vast majority of physicians take their ethical responsibilities very seriously and render a significant amount of medical care without regard to a patient's ability to pay. Emergency physicians alone render an estimated \$300 million in uncompensated medical services each year.

In addition to each physician's personal ethical standards, the subject of patient transfers has been addressed by a number of professional medical organizations. Both the American Hospital Association and the Joint Commission on Accreditation of Hospitals have guidelines relating to this area. A hospital which allows inappropriate transfers risks the possible loss of its accreditation. The American College of Emergency Physicians has itself recently adopted revised guidelines concerning patient transfers from emergency departments, and a copy of those guidelines accompanies this statement.

Of more immediate impact to the individual physician is the ever-present threat of liability in tort. It is now well established that a physician who authorizes a transfer which endangers a patient's life or health may be sued as a result for medical malpractice. Typical of recent cases in this area is *Thompson v. Sun City Community Hospital*, 141 Ariz. 597; 688 P.2d 605 (1984), in which the Arizona Supreme Court held that an aggrieved patient could recover from a hospital for any damages sustained as the result of an improper transfer.

The specter of malpractice liability has profoundly affected the practice of medicine in recent years. Most physicians are at least cognizant of the potential legal risks associated with virtually all medical procedures and some have accordingly adopted extremely conservative diagnostic and treatment modalities. The result has unfortunately exerted some pressure on health care costs throughout the nation, and the recent tendency of juries to award large verdicts in malpractice cases has dramatically increased insurance premiums. Annual malpractice insurance premiums in obstetrics and some surgical specialties now approach \$100,000 in some states, and the availability of coverage for some disciplines is increasingly in doubt.

Faced with mounting insurance costs and the increasing prevalence of patient lawsuits, some physicians have reluctantly decided to abandon or restrict their practices. There can be no question but that physician accountability through the legal system has improved, but it has not been without cost. ACEP is concerned that the introduction of criminal penalties as an additional sanction for physician error may accelerate the departure of some physicians from the profession altogether and otherwise increase costs to the public at large.

From its perspective as the representative of the nation's emergency physicians, ACEP considers the existing disincentives to improper patient transfers to be sufficient. It is almost inconceivable that any emergency physician or hospital would knowingly run the substantial risks of civil liability that would result from a decision to transfer a patient contrary to that patient's best medical inter-

ests. ACEP acknowledges the fact that inappropriate transfers are, however, sometimes made. The existing legal system and the profession's standards of conduct, however, are capable of rectifying those mistakes when they occur and ensuring a just compensation for any patient who may suffer as a consequence.

3. Practical Problems in Implementing Section 1867.—In addition to ACEP's belief that Section 1867 provides for remedies that may not be necessary or that may be counterproductive in operation, ACEP is concerned by the section's lack of definitive guidance as to the precise conduct prohibited. In general, the implicit premise underlying Section 1867 is that medical diagnosis is an exact science, susceptible in every case to precise, retrospective evaluation. Such, unfortunately, is not always the case. Emergency physicians, in particular, are often called upon to make rapid, difficult decisions concerning a patient's treatment which may include judgments as to the medical advisability of a transfer to another facility. Not every physician may agree in all instances as to the proper course of treatment, but the existence of professional disagreement does not necessarily indicate sub-standard care.

The difficulty with Section 1867 is that it is nondiscriminating in its application. Physicians may face the prospect of imprisonment and fines despite the fact that they have rendered the best possible care under the circumstances. The test of "gross deviation from the prevailing local standards of medical practice" as set forth in Section 1867 is inherently capable of a variety of interpretations.

Most disturbing is the fact that Section 1867 will, in fact, be interpreted and enforced not by medical peers but by U.S. Attorneys. ACEP believes that the interjection of non-physician review of the most intimate diagnostic decision-making is not only inadvisable as a matter of policy but contrary to the admonition of Section 1801 of the Medicare Act, 42 U.S.C. § 1395, that "[n]othing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided . . ."

Further, the practical operation of Section 1867 in many cases will be to place emergency physicians in the intractable position of having to provide extended care to emergency patients who might encounter some risk in transport. Most emergency physicians do not have admitting privileges in the hospitals where they practice. Should an emergency physician be unable to locate a staff doctor willing to admit and accept responsibility for the treatment of a patient, the emergency physician will then be faced with the impossible choice of either transferring the patient and risking eventual prosecution or retaining the patient in the emergency department, effectively on an inpatient basis.

Section 1867 will have a particularly harsh impact on the nation's small and rural medical facilities. Many hospitals of this sort operate emergency departments, but many of them are not fully staffed by physicians on a twenty-four hour basis and depend instead upon the services of skilled nurses who initially evaluate the patient's condition and on physicians who are on call outside the hospital. These hospitals sometimes provide the only first-aid and life-saving facilities in their communities, but they will be particularly vulnerable because of their limited resources to inadvertent

violations of Section 1867's requirements. A physician who is not physically present in such an emergency department but who is nonetheless on call and a "responsible physician" as defined in Section 1867(d)(4)(B) will be confronted with the prospect of criminal sanctions if he or she should authorize a patient transfer because it appears to be in the patient's best medical interests in light of the resources available at the transferring hospital at the time the patient is seen.

In addition, it is not clear from the language of Section 1867(a) what "an appropriate medical screening examination" is or who is required to provide it. The practice of emergency medicine has undergone considerable change in the past decade as new delivery systems such as regional trauma centers and areawide telecommunications networks have evolved for the purpose of directing patients to the nearest appropriate medical facility as quickly as possible. It is sometimes the case that preliminary evaluations of a patient's condition must take place on an urgent basis and occasionally by means of radio contact with rescue units on the scene. The requirement of providing a complete medical screening examination prior to transfer may simply be impossible to fulfill in all circumstances and may often be contrary to the patient's best medical interests in obtaining prompt medical attention at the most appropriate facility.

ACEP is also concerned by the requirement of Section 1867(c)(2)(A)(ii) that the agreement of the receiving facility be obtained in all circumstances before a patient transfer is initiated. There have been instances in which non-physician administrative personnel at some medical facilities have intervened to block or countermand patient transfers already agreed upon between responsible physicians. It is ACEP's position that a decision as to medical advisability of any transfer is a medical determination to be made by the physicians on the scene and that administrative concerns should not interfere with that process. Just as the transferring hospital has a responsibility to conduct a patient transfer in a safe and appropriate manner, so too does the receiving hospital have a responsibility not to refuse a transfer arbitrarily when otherwise indicated.

ACEP believes that the civil enforcement provisions incorporated at Section 1867(d)(3) may potentially serve only to aggravate relations among hospitals in particular localities. The inclusion of "any entity" among those eligible to claim damages as a result of an inappropriate transfer may lead to the unfortunate spectacle of hospitals bringing suit against each other over patient transfer disagreements. The resolution of individual transfer situations can often best be handled on a more informal basis; the judicial system is particularly ill-equipped to mediate such disputes.

Further, ACEP is in doubt as to the potential implications of Section 1867(d)(3)'s stipulation that an action for damages may be brought "in an appropriate court of general jurisdiction of the state in which the hospital is located or in the appropriate Federal district court." This provision may simply be an acknowledgment that certain actions will inevitably be filed in the federal courts as a part of their diversity of citizenship jurisdiction. It may, however, also be interpreted to create a new federal question basis for dis-

strict court jurisdiction over cases arising out of Section 1867. If the latter, the result will be federal court adjudication of what are essentially medical malpractice cases now handled almost exclusively in state courts.

At the very least, ACEP doubts whether it is appropriate to provide for equitable sanctions in addition to the fines and other penalties already set forth in Section 1867. Each patient must necessarily be evaluated and treated on an individual basis, and it is not likely to be the case that separate patient transfers will share many of the same characteristics. Nonetheless, if injunctive relief is entered to restrain future patient transfers, it will be very difficult for a court to frame such an order and for an affected hospital or physician to know precisely what conduct has been restrained. The inevitable result may be continuing judicial supervision of ongoing medical decision-making, the kind of active judicial management of technical issues which most courts are reluctant to undertake.

The inherent ambiguity in many of Section 1867's provisions is illustrated by the definition of "to stabilize" as set forth in Section 1867(e)(4)(A). That definition stipulates that emergency medical treatment must be provided to a patient sufficient "to assure" that the patient's condition will not likely deteriorate as the result of a transfer. The practice of medicine is not, however, an exact science, and rigid guarantees and assurances as to the probable course of any illness or injury are simply not within the capacity of any physician to provide.

4. Alternative Solutions.—ACEP strongly believes that the subject of patient transfers and emergency medical care in general is sufficiently important to warrant careful and deliberate study by the Congress. The text of Section 1867 originated with the House Ways and Means Committee's deliberations on the Deficit Reduction Amendments of 1985, and no public hearings on Section 1867 have yet been held. The actual text of this legislation has been publicly available for only a few weeks. There is thus the distinct possibility that the bill may be enacted with virtually no opportunity for public comment and within the space of less than two months from start to finish.

Section 1867 is, however, a dramatic and controversial addition to federal law. ACEP believes that this legislation deserves careful and considered attention with an opportunity for the Congress to receive and evaluate the opinions of interested persons and organizations. It should not be enacted in haste as a part of the annual budget process.

Accordingly, ACEP would respectfully suggest that Section 1867 be severed from H.R. 3128 so that its merits and probable impact on American medicine can be separately evaluated. The subject is far too important to be resolved by the enactment of criminal penalties as the panacea for a situation which is inadequately understood.

In this regard, ACEP would support legislation directing the Secretary of Health and Human Services to undertake a comprehensive study to determine the scope and dimensions of indigent health care needs in the United States. Such a study would constitute an invaluable contribution to our understanding of an impor-

tant aspect of American health care. There is insufficient information on the degree to which the medical requirements of the poor are now being met, and it is time that a careful analysis be conducted of the impact on indigent health care of recent changes in the health care industry. One part of this study could appropriately be devoted to an examination of the incidence and effects of patient transfers.

With specific regard to emergency medical treatment, ACEP supports the concept that all hospitals should be required to develop plans governing the provision of emergency medical services and setting forth the procedures to be followed when transferring a patient to another facility. If necessary, such a requirement could be included as a condition of participation for Medicare reimbursement. The objective would be to ensure that every patient is provided with appropriate emergency medical treatment regardless of that patient's ability to pay.

Many states now enforce such standards either through legislation or by judicial interpretation, and the enforcement of such state legislation and the adjudication of claims on behalf of aggrieved patients should continue to be matters of administrative action and civil litigation. There is very little indication that these remedies have proven to be inadequate in the past. The use of federal criminal sanctions in a field such as emergency medicine which is characterized by subjective judgment and urgent decision-making is peculiarly inappropriate. The potential penalties are draconian in degree. Not only may some physicians be faced with lengthy prison terms and substantial fines for a mistake in judgment, but their future livelihood may effectively be destroyed. Most states automatically revoke a medical license upon conviction of a felony. The addition of criminal penalties to civil liability to loss of the ability to practice medicine amounts to the sort of cumulative sanctions that are both unnecessary and extraordinarily harsh.

If enacted as currently written, Section 1867 will take effect on October 1, 1985, only days after it is likely to be signed into law. There will be virtually no time for physicians across the country to know and understand their duties under the law and the possible penalties they may encounter. ACEP believes that the goals and objectives of Section 1867 are worthy of support, but that the means proposed may unfortunately prove to be disastrous in application.

The American College of Emergency Physicians firmly believes in the right of every patient to be treated with dignity and compassion. Adequate medical care should be available to every individual, regardless of economic status. As the national professional society of emergency physicians, ACEP will continue to support measures designed to strengthen and improve the provision of emergency medical services and to attain the goal of a society in which access to medical care is available to every person in need. Inappropriate patient transfers are only one manifestation of the fact that America has not yet reached that goal. A resolution to this issue can be found, but it must be a solution which combines concern for the rights and dignity of the individual patient with an appreciation for the difficult and demanding challenges of the profession of emergency medicine.

The American College of Emergency Physicians stands ready to work with the Congress in formulating a reasonable and effective solution to this important issue.

POLICY STATEMENT ON TRANSFER OF PATIENTS¹

From time to time, patients in an Emergency Department are transferred to other facilities. The transfer may be to another Emergency Department or directly to an inpatient facility. Clearly, not all physicians or medical facilities have the capabilities to care for every patient. At times, patients or those responsible for them, request transfer to another facility for various reasons (which may or may not be medical); at times patients are transferred to receive the benefit of more appropriate facilities and/or services than are available in the given hospital or Emergency Department; and at times patients are transferred because of economic considerations, which may include the availability of free or reduced-cost medical care at a public or other facility or in accordance with the requirements of pre-existing contracts for patients of prepaid health plans that stipulate which facilities patients are to use.

Patients should not be transferred to another facility without first being stabilized. Stabilization includes adequate evaluation and initiation of treatment to assure the transfer of a patient will not, within reasonable medical probability, result in death, or loss or serious impairment of bodily parts or organs.

Stabilization of patients prior to transfer should include:

1. Establishing and assuring an adequate airway and adequate ventilation.
2. Initiating control of hemorrhage.
3. Stabilizing and splinting the spine or fractures when indicated.
4. Establishing and maintaining adequate access routes for fluid administration.
5. Initiating adequate fluid and/or blood replacement.
6. Determining that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion. The vital signs should remain within these parameters for a sufficient time prior to transfer to be reasonably certain they will not deteriorate while en route to the receiving hospital. However, there may be times when stabilization of a patient's vital signs is not possible because the hospital or Emergency Department does not have the appropriate personnel or equipment needed to correct the underlying process (e.g., thoracic surgeon on staff or cardiopulmonary bypass capability). In these cases, numbers 1-5 of the above should be performed and transfer carried out as quickly as possible.

At times, a patient or those responsible for the patient, may request a transfer that seems medically inappropriate. The physician is obliged to explain the medical risks involved, and an informed consent should be signed by the patient (or those responsible for the patient such as a parent or guardian) and the physician. In the event of such a transfer, the physician should still use every re-

¹ Approved by the ACEP Board of Directors on August 13, 1985. These are guidelines and are not to be construed as standards of care.

source available in an attempt to stabilize the patient prior to transfer.

The following guidelines should be observed for transfer of patients:

1. The patient should be transferred to a facility appropriate to the medical needs of the patient. The facility should have adequate space and personnel available to care for the patient.

2. A physician or other responsible person at the receiving hospital must agree to accept the patient transfer prior to the transfer taking place. Acceptable "other responsible persons" should be medical personnel who are designated by the hospital and given the authority to accept the transfer of the patient. The patient transfer should not be refused by the receiving hospital when the transfer is indicated and the receiving hospital has the capability and/or responsibility to provide care to the patient.

3. Communication between responsible persons at the transferring and receiving hospitals for purposes of exchanging clinical information should occur prior to transfer. Ideally, this communication should be physician-to-physician.

4. Once a patient is accepted for transfer, an appropriate medical summary and other records (including lab results and copies of EKGs and X-rays) should be sent with the patient.

5. A patient should be transferred via a vehicle that has appropriately trained personnel and life-support equipment. At times, it may be necessary for additional specialized personnel from the transferring or receiving hospital to accompany the patient.

At times, transfer of patients occurs routinely or is part of a regionalized plan for obtaining optimal care for patients at more appropriate and/or specialized facilities. In these situations there should be:

1. Written guidelines (e.g., types of cases appropriate for transfer) to govern the transfer of patients;

2. Pre-existing transfer agreements between the facilities, and;

3. Pre-transfer communication between appropriate responsible personnel.

OMNIBUS BUDGET RECONCILIATION ACT OF 1985

R E P O R T

OF THE

COMMITTEE ON THE BUDGET HOUSE OF REPRESENTATIVES

TO ACCOMPANY

H.R. 3500

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SECTION 2 OF THE FIRST CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 1986

together with

SUPPLEMENTAL, ADDITIONAL, AND MINORITY
VIEWS



Serial No. R-2

OCTOBER 3, 1985.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

No material re Social Security in this report.

99TH CONGRESS
1st Session

SENATE

REPORT
99-146

CONSOLIDATED OMNIBUS BUDGET
RECONCILIATION ACT OF 1985

R E P O R T

OF THE

COMMITTEE ON THE BUDGET
UNITED STATES SENATE

TO ACCOMPANY

S. 1730

A BILL TO PROVIDE FOR RECONCILIATION PURSUANT TO SECTION 2 OF THE FIRST CONCURRENT RESOLUTION ON THE BUDGET FOR FISCAL YEAR 1986 (S. CON. RES. 32, NINETY-NINTH CONGRESS)



OCTOBER 2 (legislative day, SEPTEMBER 30), 1985.—Ordered to be printed

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CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT
OF 1985

OCTOBER 2 (legislative day, SEPTEMBER 30), 1985.—Ordered to be printed

Mr. DOMENICI, from the Committee on the Budget,
submitted the following

REPORT

[To accompany S. 730]

The Committee on the Budget, to which were submitted recommendations pursuant to section 2 of the First Concurrent Resolution on the Budget for Fiscal Year 1986 (S. Con. Res. 32, Ninety-ninth Congress), having considered the same, reports favorably thereon and recommends that the bill embodying those recommendations do pass.

VIEWS OF THE COMMITTEE ON THE BUDGET

Reconciliation is an important tool to restrain Federal spending. It is authorized and described in Title III of the Congressional Budget and Impoundment Control Act of 1974 (Pub. L. 93-344). The reconciliation procedure allows Congress to consider changes in spending and revenues within the purview of several committees in a single bill, while reserving to those committees the power to determine what changes will be made in laws within their respective jurisdiction.

On August 1, 1985, Congress adopted S. Con. Res. 32, the First Concurrent Resolution on the Budget for Fiscal Year 1986. That resolution mandated major reductions in the staggering budget deficits now facing the United States. Revenue and spending targets for the fiscal years 1986 through 1988 contained in the resolution will lower deficits over the next 3 years by \$276.2 billion.

In order to realize the fiscal policy set forth in S. Con. Res. 32, Congress included in that resolution instructions to 11 Senate committees and 14 House committees to recommend changes in laws in their jurisdiction which would reduce Federal spending by \$20.1 billion in budget authority and \$67.1 in outlays during FY 1986 through FY 1988. In addition, the Senate Finance and House Ways and Means Committees were instructed to recommend revenue increases totaling \$8.4 billion during that 3-year period.

All reconciled committees were instructed to submit their recommendations to the Senate Budget Committee that have met their deadlines. The Senate Budget Committee is responsible for combining these legislative recommendations into a single bill and for reporting these recommendations to the Senate without substantive revision. This report summarizes the views of the Committee on the Budget on the material submitted by the individual committees.

RECONCILIATION IS A NECESSARY TOOL TO ACHIEVE SAVINGS

The Senate Budget Committee believes that the reconciliation process as used by the Congress since 1981 is a necessary procedure through which to achieve many of the dramatic reductions in Federal spending mandated by the Congress when it approved S. Con. Res. 32, the First Concurrent Budget Resolution for FY 1986. Reconciliation allows the individual authorizing committees to work their wills on programs within their jurisdiction, as the rules of the Senate provide. This safeguard insures that the Senate will have the best judgement of individual committees on restraint on federal programs.

THIS BILL AND REPORT

Pursuant to section 310(c)(2) of the Budget Act, the Budget Committee reports herewith the recommendation of 11 Senate committees, without any substantive revision, and with a recommendation that the bill does pass.

NONBUDGETARY PROVISIONS

The Budget Committee believes that the inclusion of non-budgetary provisions in a reconciliation bill is inconsistent with the spirit and letter of the Budget Act, damages the credibility of the budget process, and could have the effect of circumventing Rule XXII of the Standing Rules of the Senate.

The problem of so-called "extraneous matters" became a major issue in 1981, during Senate consideration of S. 1377, the Omnibus Reconciliation Act of 1981. A number of provisions which were determined to be clearly extraneous were stricken from that bill. A special time agreement was entered into with respect to other provisions which some Senators contended were extraneous.

The Budget Committee has authorized the Chairman and Ranking Minority Member to consult with the Chairman and Ranking Minority Members of committees which have submitted legislation, and with the Senate Majority and Minority leadership, to identify any clearly extraneous matters in this bill and to reach an agreement on any amendments which may be necessary to eliminate such matters from the bill. The Budget Committee recommends that such amendments as agreed upon be adopted by the Senate.

SUMMARY OF RECONCILIATION RESPONSES

The total reductions in deficits as reported by the 11 Senate committees exceed by \$10.1 billion the total deficit reduction instructions given by the Congress through reconciliation for FY 1986-88. According to Congressional Budget Office estimates, 10 of the 11 reconciled Senate committees exceeded their deficit-reduction goals.

Moreover, Congress assumed additional savings would be made through the appropriations process. These savings, which were not reconciled, total approximately \$37 billion for FY 1986. If these savings are achieved, coupled with the savings included in this bill, then the Congress will have exceeded its target of \$55.5 billion in deficit reduction for FY 1986. If, in addition, the appropriations process in FY 1987 and FY 1988 also meet assumed targets for savings, and other assumed non-appropriations actions occur, then the entire deficit-reduction package of \$276.2 billion for the 3-years period will be exceeded.

RECONCILIATION PROCEDURE

Just as the Budget Act provides for the reconciliation procedure, it provides in sections 310(e) and 305 special rules for the consideration of reconciliation bills.

The following rules apply to the consideration of a reconciliation bill in the Senate:

First, debate on any reconciliation bill and all amendments thereto and debatable motions and appeals in connection therewith is limited to 20 hours.

Second, debate on the bill (including amendments, debatable motions, and appeals) shall be equally divided between, and controlled by, the majority leader and the minority leader or their designees.

Third, debate on any amendment is limited to 2 hours, divided between the mover of the amendment and the manager of the bill.

Fourth, debate on any amendment to an amendment, debatable motion, or appeal is limited to 1 hour, divided between the mover and the manager.

Fifth, a motion to limit debate to less than 20 hours is not debatable.

Sixth, a motion to recommit is not in order unless it contains instructions to report back within a specified time, not to exceed 3 days, and debate on such a motion is limited to 1 hour, divided between the mover and the manager.

Seventh, any germane amendment which amends the bill in more than one place and which achieves or maintains mathematical consistency is always in order.

Eighth, amendments to the bill must be "germane to the provisions of" the legislation. The "germaneness rule" has been interpreted as prohibiting any amendment which introduces "new subject matter."

The instructed committees, therefore, set the parameters of germaneness, as the Budget Committee reports what is submitted to it without any substantive revision.

The "germaneness rule" does not apply to a motion to recommit the bill with instructions to report a specific amendment, if a committee has not complied with its reconciliation instructions, and if the effect of the motion would be to bring the bill into compliance with the reconciliation instructions.

Ninth, floor consideration of the conference report on a reconciliation bill is in order any time after the third day following the day on which the conference report is reported and is available to Senators. Debate on the conference report is limited to 10 hours, divided equally, with debate on any appeal or motion limited to 1 hour divided between the mover and the manager.

SUMMARY OF RECONCILIATION RECOMMENDATIONS

The following tables summarize the savings achieved by the committees instructed by the Congress to make changes in programs in their jurisdiction in order to reduce spending and increase revenues in FY 1986-88. The tables compare the legislation reported by the committees to the reconciliation instructions they received from the Congress.

Table 1 provides an overall comparison of the reported bill to the reconciliation instructions. It shows that the recommendations in the bill achieve \$85.7 billion in deficit reductions over FY 1986-88, which is \$10.1 more than the instruction to the committees. Table 2 provides a summary of outlay reductions by committee. Table 3 provides details of the savings within each committee submission.

Of the 11 Senate committees receiving reconciliation instructions, six received instructions for both budget authority and outlays and five received instructions only for outlays. In table 3 that follows, budget authority estimates in the reported bill are shown only for those committees that received budget authority reconciliation instructions.

The dollar amounts in the tables, except in one instance as noted, have been estimated by the Congressional Budget Office based on the submissions of the 11 committees to the Budget Committee. Details may not add to totals due to rounding.

*Table 1***SUMMARY OF SAVINGS**

[In millions of dollars]

	FY 1986	FY 1987	FY 1988	Total FY 1986-88
RECOMMENDATIONS IN BILL				
Reductions in outlays.....	-19,397	-22,071	-28,426	-69,895
Increase in revenues	2,225	6,269	7,263	15,757
Reduction in deficit	-21,622	-28,340	-35,689	-85,652
RECONCILIATION INSTRUCTIONS TO COMMITTEES				
Reductions in outlays.....	-17,582	-21,036	-28,517	-67,135
Increase in revenues	1,800	3,000	3,600	8,400
Reduction in deficit	-19,382	-24,036	-32,117	-75,535

Table 2

SUMMARY OF OUTLAY REDUCTIONS BY COMMITTEE

[In millions of dollars]

	FY 1986	FY 1987	FY 1988	Total FY 1986-88
Agriculture, Nutrition, and Forestry.....	-2,222	-2,561	-3,301	-8,084
Armed Services	-146	-118	-150	-414
Banking, Housing, and Urban Affairs.....	-2,898	-3,706	-3,860	-10,464
Commerce, Science, and Transportation...	-349	-204	-222	-775
Energy and Natural Resources	-5,919	298	-412	-6,034
Environment and Public Works	-250	-1,200	-1,550	-3,000
Finance	-3,017	-8,042	-11,348	-22,407
Governmental Affairs	-3,473	-4,532	-5,167	-13,172
Labor and Human Resources	-340	-500	-835	-1,675
Small Business	-503	-1,026	-1,044	-2,573
Veterans' Affairs	-280	-480	-537	-1,297
Total outlay reductions in bill	-19,397	-22,071	-28,426	-69,895
Total outlay instruction to com- mittees.....	-17,582	-21,036	-28,517	-67,135

Table 3

SAVINGS BY COMMITTEE

[In millions of dollars]

		FY 1986	FY 1987	FY 1988	Total FY 1986-88
TITLE I					
AGRICULTURE, NUTRITION, AND FORESTRY COMMITTEE					
Export sales of dairy products.	O	-107	-110	-114	-331
Agriculture and rural credit ...	O	-1,998	-2,259	-2,910	-7,167
Food stamps.....	O	-117	-192	-277	-586
Total spending reduction in title I.	O	-2,222	-2,561	-3,301	-8,084
Reconciliation instruction to committee.	O	-1,250	-2,050	-4,600	-7,900
TITLE II					
ARMED SERVICES COMMITTEE					
Military pay.....	O	-146	-3	0	-149
Medicare reimbursement for CHAMPUS patients.	O	0	-115	-150	-265
Total spending reduction in title II.	O	-146	-118	-150	-414
Reconciliation instruction to committee.	O	-100	-200	-300	-600
TITLE III					
BANKING, HOUSING, AND URBAN AFFAIRS COMMITTEE					
Rural housing.....	BA	-1,588	-1,949	-2,032	-5,569
	O	-1,171	-1,764	-1,828	-4,763
Public housing operating subsidies.	BA	-288	-327	-360	-975
	O	-144	-307	-342	-793
Section 108 loan guarantees....	BA	-4	12	-62	-54
	O	-12	-46	-78	-136
Public housing debt forgiveness.	BA	-497	-467	-463	-1,427
	O	-1,567	-1,567	-1,567	-4,701

Table 3—Continued
SAVINGS BY COMMITTEE—Continued
 [In millions of dollars]

		FY 1986	FY 1987	FY 1988	Total FY 1986-88
TITLE III—Continued					
Urban development action grants (UDAG).	BA	-88	-91	-95	-274
	O	-4	-22	-45	-71
Total spending reduction in title III.	BA	-2,465	-2,822	-3,012	-8,299
	O	-2,898	-3,706	-3,860	-10,464
Reconciliation instruction to committee.	BA	-2,374	-2,828	-2,998	-8,200
	O	-2,814	-3,685	-3,821	-10,320
TITLE IV					
COMMERCE, SCIENCE, AND TRANSPORTATION COMMITTEE					
Local rail service assistance	BA	-7	-8	-8	-23
	O	-1	-3	-6	-10
Amtrak	BA	-131	-136	-142	-409
	O	-114	-128	-141	-383
Corporation for Public Broadcasting.	BA	-1	2	11	12
	O	-(*)	-(*)	7	7
Federal Communications Commission.	BA	1	-31	-35	-65
	O	1	-31	-35	-65
Ship construction differential subsidies.	BA	-200	0	0	-200
	O	-200	0	0	-200
National Oceanic and Atmospheric Administration.	BA	-32	-33	-37	-102
	O	-26	-33	-37	-96
Maritime Administration.....	BA	-10	-10	-10	-30
	O	-8	-10	-10	-28
U.S. Travel and Tourism Administration.	BA	-(*)	0	(*)	-(*)
	O	-(*)	0	(*)	-(*)
Total spending reduction in title IV.	BA	-381	-216	-221	-818
	O	-349	-204	-222	-775
Reconciliation instruction to committee.	BA	-328	-133	-135	-596
	O	-310	-119	-130	-559
TITLE V					
ENERGY AND NATURAL RESOURCES COMMITTEE					
Strategic petroleum reserve	BA	-1,471	-1,185	-1,335	-3,991
	O	-1,359	-1,331	-1,313	-4,003
Uranium enrichment.....	BA	-80	-98	-136	-314

Table 3—Continued
SAVINGS BY COMMITTEE—Continued
 [In millions of dollars]

		FY 1986	FY 1987	FY 1988	Total FY 1986-88
TITLE V—Continued					
	O	-51	-84	-120	-255
Shared-energy savings	BA	(*)	-2	-4	-7
	O	(*)	-2	-4	-7
Outer Continental Shelf ¹	BA	-4,509	1,715	1,025	-1,769
	O	-4,509	1,715	1,025	-1,769
<hr/>					
Total spending reduction or increase in title V.	BA	-6,060	430	-450	-6,081
	O	-5,919	298	-412	-6,034
Reconciliation instruction to committee.	BA	-5,485	291	-337	-5,531
	O	-5,403	147	-314	-5,570
<hr/>					
TITLE VI					
ENVIRONMENT AND PUBLIC WORKS COMMITTEE					
Federal-aid highways	O	-250	-1,200	-1,550	-3,000
<hr/>					
Total spending reduction in title VI.	O	-250	-1,200	-1,550	-3,000
Reconciliation instruction to committee.	O	-200	-850	-1,050	-2,100
<hr/>					
TITLE VII					
FINANCE COMMITTEE SPENDING PROVISIONS					
Medicare	O	-2,645	-3,906	-5,724	-12,275
Medicaid	O	-40	-140	-145	-325
Social security	O	4	5	5	14
AFDC	O	-1	-3	-4	-8
Foster care and adoption assistance.	O	3	2	3	8
Unemployment compensation.	O	-1	-1	-1	-3
Customs fees	O	-170	-245	-255	-670
Trade adjustment assistance ...	O	-5	-6	-7	-18

Table 3—Continued
SAVINGS BY COMMITTEE—Continued
 [In millions of dollars]

		FY 1986	FY 1987	FY 1988	Total FY 1986-88
TITLE VII—Continued					
General revenue sharing.....	O	0	-3,526	-4,956	-8,482
Pension Benefit Guarantee Corporation.	O	-163	-216	-243	-622
Tobacco program improvements.	O	-68	-75	-92	-235
Medicare for State and local employees.	O	0	(*)	2	2
Additional Customs personnel.	O	25	25	25	75
Additional IRS personnel.....	O	43	43	43	129
Modify reimbursement for attorney's fees.	O	1	1	1	3
Total spending reduction in title VII.	O	-3,017	-8,042	-11,348	-22,407
Reconciliation instruction to committee.	O	-3,307	-7,951	-10,908	-22,166
TITLE VII					
FINANCE COMMITTEE REVENUE PROVISIONS					
Tobacco excise tax		1,547	1,697	1,701	4,945
Extend medicare coverage for State and local workers.		0	2,251	2,456	4,707
Superfund excise tax.....		243	684	730	1,657
Limit income averaging.....		133	541	589	1,263
Research and development tax allocation moratorium.		-191	-96	0	-287
Railroad unemployment insurance tax.		0	101	98	199
Increase Customs collections...		150	450	615	1,215
Increase IRS collections.....		365	744	928	2,037

Table 3—Continued
SAVINGS BY COMMITTEE—Continued

[In millions of dollars]

		FY 1986	FY 1987	FY 1988	Total FY 1986-88
TITLE VII—Continued					
Alternate minimum tax for insolvents.		-20	-100	-139	-259
Trade adjustment assistance import tax.		0	0	289	289
Gulf coast waste disposal authority to issue IDB's.		-1	-2	-3	-6
Social security tax treatment for American Samoa.		-1	-1	-1	-3
Total revenue increases in title VII.		2,225	6,269	7,263	15,757
Reconciliation instruction to committee.		1,800	3,000	3,600	8,400
Total deficit reductions in title VII.		-5,242	-14,311	-18,611	-38,164
Reconciliation instruction to committee.		-5,107	-10,951	-14,508	-30,566
TITLE VIII					
GOVERNMENTAL AFFAIRS COMMITTEE					
Civilian agency pay	O	-1,232	-2,120	-2,557	-5,909
DOD civilian pay	O	-904	-1,680	-2,061	-4,645
2,087-hour workyear	O	-160	-160	-170	-490
Postal Service programs	O	-20	-82	-89	-191
Federal employees health benefits programs.	O	-1,067	-300	0	-1,367
Civilian agency government contracting.	O	-90	-190	-290	-570
Total spending reduction in title VIII.	O	-3,473	-4,532	-5,167	-13,172
Reconciliation instruction to committee.	O	-3,219	-4,421	-4,986	-12,626

Table 3—Continued
SAVINGS BY COMMITTEE—Continued

[In millions of dollars]

		FY 1986	FY 1987	FY 1988	Total FY 1986-88
TITLE IX					
LABOR AND HUMAN RESOURCES COMMITTEE					
Walsh-Healey overtime pro- vision.	BA	-570	-610	-635	-1,815
	O	-70	-285	-510	-865
Guaranteed student loans.....	BA	-315	-225	-325	-865
	O	-270	-215	-325	-810
Graduate medical education....	BA	(*)	0	0	(*)
	O	(*)	0	0	(*)
Total spending reduc- tion in title IX.	BA	-885	-835	-960	-2,680
	O	-340	-500	-835	-1,675
Reconciliation instruc- tion to committee.	BA	-670	-860	-1,085	-2,615
	O	-170	-535	960	-1,665
TITLE X					
SMALL BUSINESS COMMITTEE					
SBA business programs.....	BA	-460	-628	-659	-1,747
	O	-374	-605	-588	-1,566
SBA disaster program.....	BA	0	0	-459	-459
	O	-129	-421	-457	-1,007
Total spending reduc- tion in title X.	BA	-460	-628	-1,118	-2,206
	O	-503	1,026	-1,044	-2,573
Reconciliation instruc- tion to committee.	BA	-448	-564	-1,060	-2,072
	O	-509	-972	-998	-2,479
TITLE XI					
VETERANS' AFFAIRS COMMITTEE					
Medical care	BA	-253	-446	-504	-1,203
	O	-250	-440	-498	-1,188
Compensation.....	BA	-34	-40	-39	-113
	O	-30	-40	-39	-109
Total spending reduc- tion in title XI.	BA	-287	-486	-543	-1,316
	O	-280	-480	-537	-1,297
Reconciliation instruc- tion to committee.	BA	-300	-400	-450	-1,150
	O	-300	-400	-450	-1,150

*Less than \$500 thousand.

¹The estimate in the budget resolution for OCS receipts was prepared by the House Budget Committee. The CBO estimate of the same provision produces savings \$0.4 billion below the House estimate over the 3 years, 1986-88, due to different technical assumptions. Estimates of OCS savings in this table have been revised upward to reflect these technical differences.

RULE XXVI

In compliance with Rule XXVI, paragraphs 11(b) (regulatory impact) and 12 (comparative prints of proposed legislation) of the Standing Rules of the Senate, it is the opinion of the Budget Committee that it is necessary to dispense with these requirements of the rule in order to expedite the business of the Senate.

However, with respect to any committee which has submitted reconciliation recommendations and has transmitted to the Budget Committee a regulatory impact statement or a comparative print of proposed legislation, this material is incorporated in this report without revision, in the title-by-title analysis.

ROLLCALL VOTES IN COMMITTEE

Votes taken during Committee consideration of this legislation were as follows:

Domenici motion to report to the Senate the Consolidated Omnibus Budget Reconciliation Act of 1985 with a favorable recommendation and to include report language proposed by Senator Chiles regarding extraneous provisions.

YEAS

Mr. Domenici
Mr. Armstrong
Mrs. Kassebaum (by proxy)
Mr. Boschwitz (by proxy)
Mr. Hatch (by proxy)
Mr. Symms (by proxy)
Mr. Grassley (by proxy)
Mr. Kasten
Mr. Quayle
Mr. Gorton
Mr. Danforth (by proxy)
Mr. Chiles
Mr. Johnston
Mr. Sasser
Mr. Riegle
Mr. Moynihan
Mr. Exon
Mr. Lautenberg

NAYS

DELAY IN MILITARY PAY RAISE

The Department of Defense Authorization Act for Fiscal Year 1986, S. 1160, has been passed by both the Senate and the House of Representatives, and the conference report on that bill has been agreed to by the Senate. The conference version of S. 1160 provides that the rates of basic pay, basic allowance for quarters, and basic allowance for subsistence for all members of the uniformed services be increased by 3 percent effective on October 1, 1985.

In order to comply with the instructions contained in the First Concurrent Resolution on the Budget for Fiscal Year 1986 to obtain savings in Federal outlays in FY 1986, the Armed Services Committee reluctantly recommends that these increases in military pay be delayed until November 1, 1985. This delay has been estimated to result in a savings of \$150 million in Federal outlays in FY 1986 and would be accomplished by directing the Secretary of the Senate to make a change in S. 1160 upon enrollment to reflect the delay.

LINKAGE OF CHAMPUS AND CHAMPVA TO MEDICARE

Section 931 of the Department of Defense Authorization Act for Fiscal Year 1985 included provisions authorizing the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA) to utilize Medicare reimbursement procedures in paying for care under these programs. However, CHAMPUS beneficiaries form a relatively small proportion of the health care beneficiaries in the nation (less than 1 percent of the number of Medicare enrollees and less than 3 percent of the hospital revenues) and there is little incentive for health care providers to agree to provide care to CHAMPUS beneficiaries under the cost-containing reimbursement procedures with CHAMPUS was authorized to use. This results in CHAMPUS beneficiaries being required to pay the entire cost of their care or being denied care by these providers.

Therefore, the Committee recommends provisions, requested by the Administration, which would require that any institution which chooses to participate in Medicare must also participate in CHAMPUS and CHAMPVA. These provisions would continue the important voluntary feature of Medicare, inasmuch as a provider would still retain the right to elect to participate or not to participate in the Medicare system. However, if providers elect to participate in Medicare, which because of the large market share represented by Medicare enrollees they are likely to do, they would be required also to participate in

CHAMPUS and CHAMPVA and provide care to the much smaller group covered by these programs.

The Department of Defense has estimated average annual savings of approximately \$150 million during the first five years of enactment of these provisions. However, the Committee is also aware of concerns about the effect these changes might have on various segments of the medical care provider community. Because some segments of that community bear a greater share of the costs of indigent health care, concern has surfaced about whether the addition of CHAMPUS and CHAMPVA beneficiaries, under Medicare reimbursement procedures, might not exacerbate an already difficult financial situation for those segments of the provider community.

In order to ensure that these recommended provisions may be implemented without undue adverse effects on those segments of the medical provider community, the provisions would not become effective until October 1, 1987. In the interim, a study by the Secretary of Defense and the Secretary of Health and Human Services of the issues involved would be required, and the results of that study would be transmitted to the interested committees of the Congress not later than December 1, 1985.

TABLE 1. TOTAL NET BUDGETARY EFFECT OF COMMITTEE'S RECONCILIATION PROPOSALS (By fiscal year, in millions of dollars)

	1986	1987	1988	1989	1990
<hr/>					
<u>Function 050</u>					
Budget Authority	-3,048	-144	-159	-175	-186
Outlays	-2,946	-118	-150	-167	-179
<hr/>					
<u>Function 602</u>					
Budget Authority	-3,043	-1	0	0	0
Outlays	0	0	0	0	0
<hr/>					
<u>Function 950</u>					
Budget Authority	2,847	1	0	0	0
Outlays	2,847	1	0	0	0
<hr/>					
<u>Net Budgetary Impact</u>					
Budget Authority	-3,244	-144	-159	-175	-186
Outlays	-99	-117	-150	-167	-179

Basis of Estimate

The estimated budget authority savings in the first section of the bill in 1986 are a result of the committee's direct reduction of accrual payments to the military retirement trust fund (in budget function 602) of \$2.9 billion from the current law amounts. The bill limits the authorization for appropriations in the military pay accounts in anticipation of legislation that would reduce the accrual for military retirement. The CBO estimate includes these savings even though this bill would not change the military retirement entitlement--additional legislation is required.

No reductions to the baseline as a result of the accrual proposal were made for 1987-1990, since the bill does not affect military pay account totals for these years. However, the intent of the Committee is to effect a permanent change in the military retirement system. If the legislation that is submitted by the Secretary of Defense passes, there will be reductions to the net budget authority in 1987-1990. Under the baseline methodology, these budget authority reductions could be over \$3 billion each year, depending upon the type of legislation submitted. In the next budget cycle, the method for calculating the 1987-1990 accrual charge will change. Using the new method, the reductions in budget authority could be no greater than \$1.5 billion in fiscal year 1987, and not

more than \$7.6 billion for fiscal year 1987-1990. Legislation completely eliminating all retirement benefits to those entering the service after enactment would be necessary to achieve savings of this magnitude.

Savings in the second section from a one-month delay in the military pay raise were calculated using the baseline methodology.

The third section requires institutions wishing to participate in Medicare to accept CHAMPUS patients at the same reimbursement rates applied to Medicare users. Since Medicare rates are generally lower, this section would result in savings to the federal government within function 050. Estimates of these savings were supplied by DoD. For the savings to the Federal Government by section of this bill, see Table 2.

6. ESTIMATED COST TO STATE AND LOCAL GOVERNMENT: None.
7. ESTIMATE COMPARISON: None.
8. PREVIOUS CBO ESTIMATE:

CBO prepared estimates for S. 1160 and H.R. 1872, the Senate and House versions of the Defense Authorization Bill for Fiscal Year 1986. This estimate focuses on the provisions described in the Armed Services Committee's bill for budget reconciliation purposes. The provisions in this bill are different from those in either S. 1160 or H.R. 1872. Therefore, this estimate is not directly comparable to the previous CBO estimates.

9. ESTIMATE PREPARED BY: Gene Bryton (226-2840)
Barbara Hollinshead (226-2840)
Michael McCord (226-2840)
10. ESTIMATE APPROVED BY:

J. L. Blum
for James L. Blum
Assistant Director
for Budget Analysis

[COMMITTEE PRINT]

FINANCE COMMITTEE PORTION OF RECONCILIATION REPORT

COMMITTEE ON FINANCE

Title VII

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United States Senate

COMMITTEE ON FINANCE
 WASHINGTON, DC 20510

WILLIAM DIEFENDERFER, CHIEF OF STAFF
 MICHAEL STERN, MINORITY STAFF DIRECTOR

September 27, 1985

The Honorable Pete V. Domenici
 Chairman
 Committee on the Budget
 United States Senate
 Washington, D.C. 20510

Dear Pete:

We hereby submit the statutory language implementing the recommendations of the Committee on Finance to meet its reconciliation instructions under S. Con. Res. 32, the first concurrent resolution on the budget for fiscal year 1986. Also enclosed are materials which explain these provisions.

These statutory provisions will reduce outlays for programs within the jurisdiction of the Committee on Finance by \$22.2 billion over fiscal years 1986-1988. In addition, the revenue provisions will increase Federal receipts by \$15.7 billion over the same period. This level of additional revenues provides the amount of revenues required under the conference report on S. Con. Res. 32.

Sincerely,



RUSSELL B. LONG
 Ranking Minority Member



BOB PACKWOOD
 Chairman

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A. MEDICARE

1. Payments for Inpatient Hospital Services

Current law.—Since October 1, 1983, Medicare has paid for most inpatient hospital services under the prospective payment system (PPS). Payment rates for the Federal portion of the PPS are updated each October 1. The hospital-specific portion is updated at the beginning of each hospital's reporting period.

For fiscal year 1986 and later fiscal years, the Secretary of Health and Human Services is responsible for setting payment rates at levels which will take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality, taking into account the recommendations of the Prospective Payment Assessment Commission. However, for fiscal year 1986, the increase in payment levels may not exceed the percentage increase in the hospital market basket, plus one-quarter of one percentage point.

Certain hospitals and hospital units are exempt from the prospective payment system and are paid on the basis of their reasonable costs up to a limit. The limit for each such hospital or unit is based on its costs in a base year which are annually adjusted.

Explanation of provision.—The provision would require the Secretary of Health and Human Services to provide a 0.5 percent rate of increase to the PPS rates for fiscal year 1986 and a rate of increase of no more than the hospital market basket in fiscal years 1987 and 1988. Additionally, the payment limits for PPS-exempt hospitals and units would be increased by 0.5 percent for fiscal year 1986 and by a rate of increase of no more than the hospital market basket in fiscal years 1987 and 1988.

The Secretary of Health and Human Services (HHS) has been directed to study a number of aspects of the PPS, including its provisions for compensating hospitals for the additional costs of outlier cases, the establishment of severity of illness indices, and other possible payment modifications to avoid disadvantaging hospitals that treat unusually expensive patients. It has come to the Committee's attention that burn center hospitals may be among these hospitals that will require special treatment because of the extensive treatment needs of their patients. For these hospitals, up to one-half of the burn patients may be outliers—far in excess of the percentage contemplated by the PPS. The Secretary is requested to review the adequacy of the payments being made to burn center hospitals under PPS and any problems of access that the present payment method may be creating for medicare patients and to present her findings either as part of the report that is described above or as a supplement to that report.

Effective dates.—Hospital cost reporting periods beginning on or after October 1, 1985, for the hospital-specific portion of the PPS

rates, and discharges occurring on or after October 1, 1985, for the Federal portion of the PPS rates. Hospital cost reporting periods beginning on or after October 1, 1985, for PPS-exempt hospitals.

2. Prohibit Retroactive Application of Hospital Wage Index

Current law.—Medicare payments to hospitals under the prospective payment system (PPS) must be adjusted to reflect the hospital wage level in a hospital's geographic area relative to the national average hospital wage level. The Secretary has used a Bureau of Labor Statistics index to make the required adjustment. However, because the index does not distinguish between full-time and part-time employment, the Deficit Reduction Act of 1984 (DEFRA) required the Secretary to conduct a study to develop a new index. DEFRA required that if a new index were implemented, it must be applied retroactively to payments made since October 1, 1983.

On September 3, 1985, the Secretary issued final PPS regulations which provide for a new wage index, immediately effective for cost reporting periods beginning on or after October 1, 1985. The new index, known as the "gross wage index", is derived from gross hospital wages which include salaries and wages for contracted labor, interns and residents, non-hospital cost center personnel, and hospital-based physicians. Effective January 1, 1986, the index will be applied retroactively to payments made between October 1, 1983, and September 30, 1985.

Explanation of provision.—The provision would require the Secretary to use the "gross" index to adjust PPS payments made only for discharges occurring after September 30, 1985.

Effective date.—For discharges occurring on or after October 1, 1985.

3. Reduce the Indirect Medical Education Cost Adjustment

Current law.—Additional payments are made to hospitals under Medicare's prospective payment system (PPS) for their indirect costs of approved medical education programs. These costs may be due to such factors as additional tests ordered by interns and residents as part of their training and, presumably, to the relatively more severe medical condition of patients in teaching hospitals.

Prior to implementation of PPS, an estimate was developed of how a hospital's costs increased as the ratio of the hospital's number of interns and residents to beds increased. This adjustment factor was used in setting the reimbursement limits applied under Medicare's reimbursement method in effect before PPS. For PPS, Congress doubled the adjustment factor. This doubled factor is equal to 11.59 percent for each 0.1 increase in the ratio of a hospital's full-time equivalent interns and residents to its number of beds. The Federal DRG portion of a hospital's PPS payments and any outlier payments are increased by this factor.

Explanation of provision.—The provision would reduce the indirect medical education factor from 11.59 percent to 8.7 percent on a variable, or curvilinear, basis. For fiscal years 1986 and 1987, the factor would be reduced further from 8.7 percent to 7.7 percent to take into account a new provision for a disproportionate share hospital adjustment.

Effective date.—Effective for discharges occurring on or after October 1, 1985.

4. Indirect Teaching Cost Adjustment Related to Outpatient Activities

Current law.—In addition to the DRG payments, teaching hospitals are paid amounts designed to compensate them for certain costs that are indirectly attributable to their teaching activities. The amount of this indirect teaching adjustment is based on the ratio of the hospital's residents and interns to the number of its beds. On September 3, 1985, the Secretary issued final regulations that would eliminate interns and residents who serve in the hospital's outpatient department from his ratio.

Explanation of provision.—The provision would clarify that residents and interns who serve a hospital's outpatients should be included in the ratio since the regression analysis on which the indirect teaching adjustment is based includes all of the residents and interns serving the hospital's patients.

Effective date.—Enactment.

5. Create a Disproportionate Share Hospital Adjustment

Current law.—Under the Social Security Amendments of 1983, the Secretary of HHS was required to make such adjustments to the prospective payment system (PPS) rates as the Secretary deems appropriate for hospitals that serve a disproportionate number of low-income or Medicare Part A patients. The Deficit Reduction Act of 1984 required the Secretary, prior to December 1, 1984, to develop and publish a definition of disproportionate share hospitals, to identify such hospitals, and to make the list available to the committees with legislative jurisdiction over Part A of Medicare. The Secretary has not yet done so.

Explanation of provision.—The provision would require the Secretary to make additional payments to all PPS hospitals serving a disproportionate share of low-income Medicare patients. The proxy measure for low-income Medicare patients would be the percentage of a hospital's total Medicare patient days attributable to Medicare patients who are also enrolled in the federal Supplemental Security Income (SSI) program. For hospitals with 100 beds or more, if the proxy measure is above a minimum threshold of 15 percent, the Federal portion of the PPS payment would be increased by 2 percent. An additional 2.5 percent would be paid for each 10 percentage points (or portion thereof) that the proxy measure is above the 15 percent minimum threshold, with a maximum adjustment of no greater than 12 percent. PPS rates for hospitals with less than 100 beds would be increased by 12 percent if their proxy measure is 55 percent or more.

In fiscal year 1986, the Secretary would be required to pay hospitals interim rates based on historical data with final settlement based on actual data. Upon request, the Secretary would be allowed to adjust the interim rate if a hospital provides adequate data to show that the interim rate was too high or low. The Secretary would be required to develop accurate data on Medicare patients who are also enrolled in SSI by October 1, 1986. The proposal

also requires the Secretary to pay hospitals where historical data is not available on the basis of similar hospitals in the region in which the hospital is located. The provision would expire in two years.

Effective date.—For discharges occurring on or after October 1, 1985, and before October 1, 1987.

6. Modify Direct Medical Education Cost Payments

Current law.—The direct costs of approved graduate medical and other health professional education programs (such as classroom costs and the salaries of interns and residents) are excluded from the prospective payment system (PPS) and are paid on a reasonable cost pass-through basis.

Explanation of provision.—The provision would limit payments to hospitals for their direct costs of approved medical education activities for the first cost reporting period beginning on or after July 1, 1985. The limit would be the provider's approved medical education costs during the cost reporting period ending prior to October 1, 1985, updated to reflect general increases in the cost of approved educational activities which took place between the end of the prior accounting period and the beginning of the freeze accounting period.

Beginning with the first cost reporting period beginning on or after July 1, 1986, the direct costs of medical education activities associated with those residents who are either board eligible or have completed more than five years of training will no longer be allowable, with the exception of geriatric fellowships which meet criteria established by the Secretary. The exception for geriatric fellowships expires July 1, 1991.

Also beginning with the first of a hospital's cost reporting periods beginning on or after July 1, 1986, only 66 percent of the direct educational costs of graduates of medical schools not accredited by the Liaison Committee on Medical Education (LCME), or graduates of accredited schools at osteopathy, dentistry, or podiatry will be allowable costs. The allowable percent for these so-called "foreign medical graduates" would be reduced to 33 percent in the subsequent reporting period and to zero percent thereafter. However, hospitals whose unaccredited medical school graduates represent more than 50 percent of their students as of October 1, 1985, would receive the 66 percent funding for the first two reporting periods beginning on or after July 1, 1986, 33 percent funding for the three subsequent periods, and no funding thereafter. The provision also requires the Secretary and the General Accounting Office to study and report on various aspects of graduate medical education.

Effective date.—Effective for cost reporting periods beginning on or after July 1, 1985.

7. Continue Regional Hospital Payment Systems

Current law.—The 1983 legislation (P.L. 98-21) authorizing the prospective payment system (PPS), directed the Secretary to continue certain hospital payment systems that had previously been established as demonstrations if they meet certain requirements. One requirement is that the system apply to substantially all acute care

hospitals in the State. In addition, it must review at least 75 percent of all inpatient hospital revenues or expenses in the State. Currently, statewide hospital payment systems are in effect for New Jersey, Maryland, and Massachusetts. In New York, three separate systems are in effect, covering: (a) the Rochester area, (b) the Finger Lakes area, and (c) the remainder of the State.

When New York's waiver ends December 31, 1985, neither the Rochester project nor the Finger Lakes project will be allowed to continue since they cannot meet the requirement described above.

Explanation of provision.—The provision would provide that the Rochester and Finger Lakes demonstration projects could continue under waivers of Medicare's hospital payment system if, in addition to other requirements currently in law, they meet a requirement that their hospital payment systems apply to substantially all acute care hospitals in the geographic areas served by the systems on January 1, 1985, and they must renew at least 75 percent of inpatient hospital revenues in their geographic areas.

Effective date.—Enactment.

8. Continuation of Medicare Waiver for New Jersey

Current law.—The Secretary must approve the request of a State for a waiver of Medicare's reimbursement rules for a statewide hospital reimbursement control system under Section 1886(c) of the Social Security Act if certain requirements are met. One requirement is that the State demonstrate to the Secretary's satisfaction that over 36-month periods, the amount of payments made under the waiver will not exceed the amounts that otherwise would have been paid by Medicare if the State were not under a statewide reimbursement waiver.

Explanation of provision.—The provision would prohibit the Secretary from discontinuing a State's waiver so long as the State takes appropriate steps by July 1, 1986, to assure the Secretary that its system will continue to meet the cost-effectiveness test. The provision would apply only to States which had made a request for a waiver under 1886(c) prior to December 31, 1984.

Effective date.—Enactment.

9. Transfer of Assets

Current law.—Where a State donates a hospital to a non-profit corporation, the basis for Medicare capital-related costs to the new owner is the lesser of the sales price or the prior owner's historical cost (net of depreciation).

Explanation of provision.—The provision would provide that State owned hospitals being transferred to non-profit corporations at little or no cost would retain their current Medicare book value (historical cost less depreciation) for purposes of calculating their Medicare allowance for interest and depreciation.

Effective date.—Enactment.

10. Indirect Teaching Adjustment Related to Independent Clinic Activities

Current law.—For the first three years of the prospective payment system (PPS), a special exception is applied to hospitals which had traditionally allowed direct billing under Part B so extensively that it would have been disruptive to immediately require them to bill for all such services under Part A. These hospitals were, in effect, allowed to have part of their PPS payments paid through Part B billings and the remainder paid to the hospital under Part A. The Health Care Financing Administration has ruled that in such split payment cases, the indirect teaching adjustment would apply only to the portion of the Medicare payment that is paid through Part A.

Explanation of provision.—The provision would clarify that the split payment provisions was only intended to provide a temporary billing accommodation for certain hospitals and that the indirect teaching adjustment should be applied as if the entire PPS payment had been made under Part A.

Effective date.—Enactment.

11. Coverage of Psychologists' Services

Current law.—Section 1861(b) of the Social Security Act includes in the definition of the inpatient hospital services that are paid for by Medicare "such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements."

Explanation of provision.—The provision would clarify that inpatient hospital services for which payments may be made under Medicare Part A may include diagnostic or therapeutic services provided by a psychologist. The Committee recognizes that such services are already included in the existing definition of inpatient hospital services.

Effective date.—Enactment.

12. Extend Medicare Hospice Benefit

Current law.—(a) *Sunset of hospice benefit under Medicare.* Individuals who are entitled to Medicare Part A benefits and who are certified to be terminally ill may elect to receive Part A reimbursement for hospice care services, in lieu of certain other services. Current authority for the Medicare hospice benefit is scheduled to terminate on October 1, 1986. An evaluation of the program, to be conducted by the Secretary of Health and Human Services, is due to Congress prior to January 1, 1986. However, this report will not be completed until January 1, 1988.

(b) *Payment rates.* In implementing the hospice benefit, HHS established a prospective payment system and set daily rates for each of four levels of hospice care. P.L. 98-617 increased the routine home care payment rate from the \$46.25 specified in final regulations to \$53.17, and required the Secretary to review and adjust the hospice rates annually, beginning October 1, 1985, and to report to

Congress on October 1 of each year on the adequacy of the rates to ensure participation in Medicare by an adequate number of hospice programs.

Explanation of provision.—The provision would make permanent the hospice benefit under the Medicare program. In addition, it would utilize the resulting savings by increasing each of the four hospice payment rates by \$10.00.

Effective date.—Enactment.

13. Moratorium on Medicare Laboratory Payment Demonstration

Current law.—Pursuant to demonstration authority of present law, the Secretary has proposed to experiment with competitive bidding as a method of purchasing clinical laboratory services under the Medicare program. At this time, the design of the experiments has not been developed. However, independent laboratories have expressed the concern that under the experiments unsuccessful bidders might not be eligible to participate in the Medicare program.

Explanation of provision.—The provision would postpone the demonstrations until after December 31, 1986 with the exception that the design of and site selection for such demonstrations can proceed. During this moratorium, representatives of the laboratory industry could conduct a study in collaboration with the Secretary and the U.S. General Accounting Office, to determine whether there is a less disruptive method of utilizing competitive market forces in setting Medicare payment levels—e.g., by giving Medicare access to laboratory fee schedules that have been established in competing for the business of other large purchasers. If the study is conducted, the Secretary and the GAO shall provide the study and their comments on it to the committees of jurisdiction.

Effective date.—Enactment.

14. Extend Home Health Waiver of Liability

Current law.—Current Medicare law allows Part A providers to collect payment from intermediaries after a claim has been denied because the items or services were found not to be medically reasonable and necessary or because services were determined to be custodial care. A finding must be made that neither the beneficiary nor the provider knew or could reasonably have been expected to know that the items or services were not covered. Under current administrative practice, providers can be presumed to meet this test if they meet certain criteria. The principle criterion for home health agencies is that its denial rate does not exceed 2.5 percent. The denial rate is determined by the percentage of days billed by the provider as covered that HCFA later determines to be noncovered when the bill is reviewed. Under this waiver of liability policy, home health agencies with a denial rate 2.5 percent or less are paid for these denied services.

In a proposed rule published February 12, 1985, HCFA would eliminate the criteria for a favorable presumption and determine payment on a case-by-case basis. Under the rule, home health agencies would be liable for payment for up to 2.5 percent of claims which were judged to be uncovered after HCFA review.

Explanation of provision.—The provision would require the Secretary to maintain 2.5 percent waiver of liability policy for home health agencies from the date of enactment until 12 months after the consolidation of claims processing for home health agencies, that is, when all ten Home Health Agency fiscal intermediaries begin operations.

Effective date.—Enactment.

15. Home Health Regulation Moratorium

Current law.—Prior to the recent publication of final regulations, reimbursement for home health services was limited to the 75th percentile of the average costs per visit incurred by all home health agencies. Separate limits were established for each type of service (e.g., skilled nursing, home health, and physical therapy); however, they were applied in the aggregate to each home health agency based on its mix of services.

The Administration has revised, in regulations published July 5, 1985, the home health cost limit methodology. For cost reporting periods beginning on or after July 1, 1985, the limits are set at 120 percent of the mean and would be applied separately to each type of service. For cost reporting periods beginning on or after July 1, 1986, the limits are to be reduced to 115 percent of the mean. For cost reporting periods beginning on or after July 1, 1987, the limits are to be set at 112 percent of the mean.

Explanation of provision.—The provision would delay implementation of the July 5 regulations until July 1, 1986.

Effective date.—July 1, 1985.

16. Study of Home Health Agency Supervision

Current law.—The Medicare law requires that a physician or registered nurse supervise patient care services provided by a home health agency.

Explanation of provision.—The Secretary is required to examine the question of whether other health care professionals, (e.g., physical therapists, occupational therapists, and speech-language pathologists) may be qualified to supervise patient care services provided by a home health agency. Further, the Secretary would be required to specify criteria and conditions for which they could fulfill the supervisory role. The report would be due April 1, 1986.

Effective date.—Enactment.

17. Study of Physical Therapists' Office Requirements

Current law.—Under current law, Part B of Medicare covers the services of a qualified physical therapist in independent practice when furnished by him or under his direct supervision in his office or in the patient's home. These services must be prescribed by a physician and furnished pursuant to a written plan of treatment established by a physician or a qualified physical therapist.

The Secretary is required, under present law, to establish conditions that an independently practicing physical therapist must meet in order to receive Medicare reimbursement. The Secretary, by regulation, requires that a physical therapist in independent

practice maintain an office space with the necessary equipment to provide an adequate program of physical therapy. This requirement is applied even to those therapists who operate exclusively in the beneficiary's home.

Explanation of provision.—The Secretary is required to study the requirement that independently practicing physical therapists who operate exclusively in beneficiaries' homes maintain fully-equipped offices. The report would be due April 1, 1986.

Effective date.—Enactment.

18. Extend Secondary Payer Coverage for Working Aged Over Age 69

Current law.—The Tax Equity and Fiscal Responsibility Act of 1982 required employers of 20 or more workers to offer employees aged 65 through 69, and their spouses aged 65 through 69, the same group health plans offered to employees under age 65. Where the beneficiary elects such coverage, Medicare becomes the secondary payer. The Deficit Reduction Act of 1984 extended the working aged provision to beneficiaries covered under a working spouse's employer health plan when that working spouse is under age 65.

Explanation of provision.—The provision would extend the working aged provision to beneficiaries over age 69 if they or their spouses work and elect the employer-based health insurance plan.

Effective date.—January 1, 1986.

19. End Stage Renal Disease (ESRD) Networks

Current law.—As required, the Secretary has established networks to assure the effective and efficient administration of the end-stage renal disease (ESRD) program under Medicare. The networks help assure that ESRD patients use treatment settings most compatible with successful rehabilitation; and receive quality care.

Explanation of provision.—The provision would prohibit the Secretary from dismantling ESRD networks.

Effective date.—Enactment.

20. Extension of Certain Medicare HMO Demonstration Projects

Current law.—Certain Medicare requirements may be waived when the Health Care Financing Administration enters into demonstrations under its general demonstration authority.

Explanation of provision.—The provision would require the Secretary to extend for three additional years, the four municipal health services demonstration projects (Milwaukee, Baltimore, San Jose and Cincinnati) currently authorized under Medicare demonstration authority.

Effective date.—Enactment.

21. Coverage of Respiratory Care Services for Ventilator-Dependent Individuals

Current law.—Medicare and Medicaid provide limited outpatient and home services to ventilator dependent individuals.

(a) *Medicare:* To qualify for home health services, a Medicare beneficiary must be confined to his or her home and under the care

of a physician. In addition, the person must be in need of part-time or intermittent skilled nursing care or physical or speech therapy. Once an individual qualifies for Medicare's home health benefit, the beneficiary becomes entitled to a range of home health services.

In order to qualify for Medicare's skilled nursing facility benefit, individuals must first be hospitalized for at least three consecutive days. They must also need skilled nursing or other skilled rehabilitation services on a daily basis for treatment related to the condition for which the beneficiary was hospitalized. Medicare law specifies the range of services which are covered in the skilled nursing facility.

(b) *Medicaid*: Under Medicaid, States are required to cover home health services for Medicaid recipients over 21 years of age who are categorically needy or medically needy, if such services are offered. In addition, a State must provide home health services to categorically needy recipients under 21 if such individuals are eligible to receive skilled nursing facility services under a State's Medicaid plan. States may provide such services to other program recipients.

Explanation of provision.—The provision would amend Medicare law to allow qualified respiratory care patients to qualify for Medicare's home health and skilled nursing facility benefits and would include among covered services respiratory care for such individuals. The provision defines "qualified respiratory care patient" as an individual who has been hospitalized for at least 30 consecutive days, dependent on a respirator for life support at least 6 hours per day during that time, and is willing and medically able to be cared for in a less intensive setting.

The provision would also amend Medicaid to require States to cover respiratory services in the home for individuals who meet the definition of "qualified respiratory care patients".

Effective dates.—(a) *Medicare*: Services performed on or after October 1, 1988. (b) *Medicaid*: Applies to services performed on or after October 1, 1988.

22. Increase Audit Effort and Medical Claim Review

Current law.—Under current law, the Secretary contracts with intermediaries and carriers to perform the day-to-day administrative and operational tasks for the Medicare program, including the review of claims and the conduct of audits.

Explanation of provision.—The provision would require that Medicare contractor budgets for fiscal years 1986, 1987, and 1988 be supplemented by \$105 million in each year to be spent specifically for provider cost audits and medical review activities. Adequate funding of medical review, and audit and related activities is intended to achieve cost-effective program management. The increased funding will enable the program to avoid excessive benefit payments because of a failure to identify improper billings or billings for uncovered services or costs.

Effective date.—October 1, 1985.

23. Improve Access to Skilled Nursing Facilities

Current law.—Medicare provides skilled nursing facility (SNF) services under the Hospital Insurance (Part A) program.

(a) *Payment rates.*—SNF's are reimbursed on the basis of reasonable costs actually incurred, subject to limits. Medicare's final payment to a SNF is determined retrospectively only after a SNF has itemized its costs for a full year on a Medicare cost report. Separate reimbursement limits are applied to freestanding SNFs and hospital-based SNFs. For freestanding facilities, limits are established at 112 percent of the mean operating cost of urban and rural freestanding facilities respectively. Limits for urban hospital-based facilities are equal to the urban freestanding facility limits plus 50 percent of the difference between the freestanding limit and 112 percent of mean operating costs for hospital-based facilities. A similar calculation, based on costs of rural facilities, is made for rural hospital-based facilities. Cost differences between hospital-based and freestanding facilities attributable to excess overhead allocations resulting from Medicare reimbursement principles are recognized as an add-on to the limit for hospital-based facilities.

(b) *Waiver of liability.*—Current Medicare law allows Part A providers to collect payment from intermediaries after a claim has been denied because the items or services were found not to be medically reasonable and necessary or because services were determined to be custodial care. A finding must be made that neither the beneficiary nor the provider knew or could reasonably have been expected to know that the items or services were not covered. However, providers can earn a presumption, or waiver, that allows them not to be held liable for uncovered services they provided if the provider meets five procedural criteria. By meeting the criteria, providers are essentially presumed not to have known that the service would not be covered and their liability for paying for that service therefore can be waived. This is often referred to as the "waiver of liability." Under current administrative practice, a SNF is judged to meet these criteria and to have its liability for certain uncovered claims waived if its denial rate does not exceed 5 percent. The denial rate is determined by the percentage of days billed by the provider as covered that HCFA later determines to be non-covered when the bill is reviewed. Under the waiver policy, SNFs with a denial rate of 5 percent or less are paid for these denied services.

In a proposed rule published February 12, 1985, HCFA would eliminate the criteria for a favorable presumption and determine payment on a case-by-case basis. Under the rule, SNFs would be liable for payment for up to 5 percent of claims which were judged to be uncovered after HCFA review.

Explanation of provision.—The provision would provide that SNF's that provide less than 1,500 days of care per year to Medicare patients in the preceding year would have the option of being paid a prospective rate set at 105 percent of the regional mean for all SNF's in the region. The rate would be separately calculated for urban and rural areas and include all non-ancillary costs, including capital and return on investment. Those accepting the prospective rate would be required to file a minimal cost report. With respect

to ancillary services, the Secretary would be allowed to pay for those services on the basis of reasonable costs or reasonable charges. Also, to improve the evenness of administration of the benefit, the Secretary would be required to reduce the number of intermediaries to ten within 18 months of enactment and strengthen monitoring of the administration of the SNF benefit. The Secretary would be required to maintain the five percent favorable presumption waiver of liability until 30 months after enactment of this legislation.

Effective date.—Enactment.

24. Clarify Impact of Physician Fee Freeze on HMO's

Current law.—Physicians who agree to become participating physicians, that is, accept assignment for all Medicare patients, must accept Medicare's reasonable charge determination as payment in full (subject to applicable cost-sharing) for services rendered to beneficiaries. When a participating physician provides an emergency service to a Medicare beneficiary who is enrolled in a Health Maintenance Organization (HMO), the physician may bill the HMO. In this case, a participating physician does not have to accept assignment. Further, a non-participating physician is not limited as to the amount he or she can charge the HMO (as he or she would otherwise be under the physician fee freeze provisions).

Explanation of provision.—The provision would provide that participating and nonparticipating physicians can not charge HMO's more for emergency services rendered to a Medicare beneficiary than they could charge the beneficiary.

Effective date.—For items and services provided on or after October 1, 1985, and before October 1, 1986.

25. Require Timely Publication of HMO Rates

Current law.—Section 1876 of the Social Security Act provides for Medicare payments to Health Maintenance Organizations (HMO's) and Competitive Medical Plans (CMP's) enrolling Medicare beneficiaries. In general, HMO/CMPs contracting on a risk-sharing basis are financially responsible for the cost of all benefits their enrollees would otherwise be eligible for under Medicare while enrolled in these plans. Risk-contracting HMO/CMPs are paid a prospectively determined monthly capitation amount based on cost estimates known as the AAPCC, the average annual per capita cost. The Secretary is required to calculate and publish the AAPCC rates annually, but there is no time deadline by which HMO/CMPs must be notified as to the rates that will be in effect for the next calendar year. Section 1886 of the Social Security Act requires that the Secretary annually publish by September 1 the hospital payment rates to be used during the following federal fiscal year under Medicare's prospective payment system.

Explanation of provision.—The provision would require the Secretary to publish the rates for reimbursing risk-contracting HMO/CMP's for the next calendar year no later than 10 days after publication of the hospital prospective payment rates.

Effective date.—January 1, 1986.

26. Extension of Physician Fee Freeze

Current law.—Payment for physicians' services is based on Medicare's "reasonable" (i.e., allowable) charges. The reasonable charge for a service is the lowest of the actual charge, the physician's customary charge for the service, or the prevailing charge for the service in the area. If the physician accepts assignment on a claim, he or she agrees to accept Medicare's reasonable charge as payment in full (except for applicable cost sharing); in return, Medicare pays the physician directly. If the physician does not accept assignment, Medicare payments are made to the beneficiary who in turn pays the physician. In either case, the beneficiary is liable for the required deductible and coinsurance. In the case of non-assigned claims, the beneficiary is also responsible for any difference between Medicare's reasonable charge and the physician's actual charge.

The Deficit Reduction Act of 1984 (DEFRA) froze Medicare customary and prevailing charges for physicians' services for a 15-month period—July 1, 1984 through September 30, 1985. Future updates of customary and prevailing charge screens are to be made on October 1 of each year based on data recorded for the 12-month period ending the previous March 31.

DEFRA also established the concept of a "participating physician." A participating physician is one who voluntarily agrees to accept assignment on all claims for the forthcoming year. The law includes incentives for physicians to participate. Chief among these is the ability to raise actual charges during the freeze period in order to have such charges reflected in the calculation of customary charges in fiscal year 1986. Nonparticipating physicians cannot raise their actual charges during the freeze period. Nonparticipating physicians who do not comply with the freeze could be subject to civil monetary penalties or assessments, exclusion for up to five years from the Medicare program, or both.

Explanation of provision.—The provision would extend the current freeze on customary and prevailing charges for an additional year, i.e., fiscal year 1986, for physicians who are nonparticipating physicians during both fiscal years 1985 and 1986. Prevailing charges for services furnished after the freeze would not include an allowance for the lack of an increase during the freeze. The provision would also extend the freeze on actual charges of these nonparticipating physicians. This freeze on actual charges is tied to the April-June 1984 levels.

A physician who converts from a participating physician in fiscal year 1985 to a nonparticipating physician in fiscal year 1986 would have his or her actual charges made during the 12-month period ending March 31, 1985, reflected in the calculation of his or her customary charges for fiscal year 1986.

The monitoring of physicians' actual charges would be continued through fiscal year 1986, for these physicians as well as for those that were not participating physicians in either 1985 or 1986.

Any physician who signs a participation agreement for fiscal year 1986 would receive an increase in Medicare payments for that year based on the recognition of higher customary and prevailing charges. Both participating and nonparticipating physicians would

receive an increase in Medicare payments in fiscal year 1987. However, unlike participating physicians, there would be a permanent one-year lag in the prevailing charge levels applicable to those who were nonparticipating physicians in fiscal year 1985.

When physicians exercised their option in September 1985, to become participating physicians for fiscal year 1986, they will have had no way of knowing what changes the Congress will make in their reasonable charge levels for fiscal year 1986. Therefore, the provision affords all physicians a second opportunity to exercise their option for fiscal year 1986, during a 30-day period following enactment.

The provision would extend for one year the current law provision transferring \$15 million from the part B trust fund to the carriers (the contractors which administer part B) for continued administration and monitoring of the freeze and participating physician and supplier program. It would eliminate the requirement for publication of the Physician Assignment Rate List and would provide for improvements in directories of participating physicians. The provision would also require that information on the participating physician and supplier program be included in explanations of benefits (EOB's) sent to beneficiaries for unassigned claims.

The provision would provide that the freeze imposed on actual charges to beneficiaries would not apply in cases where a claim for payment is not filed because the patient chooses to pay the entire bill from private sources.

Effective date.—October 1, 1985, for payment provisions. Enactment for other provisions except that EOB changes apply to EOB's provided on or after a date specified by the Secretary but no later than April 1, 1986.

27. Hold Part B Premium at 25% of Program Costs

Current law.—Under the original Medicare law, beneficiary premiums paid for 50 percent of the cost of Part B with the remaining 50 percent financed by Federal general revenues. However, legislation enacted in 1972 provided that the percentage increase in the Part B premium could not exceed the percentage increase in social security cash benefits payments. As a result, beneficiary premiums financed less than 25 percent of program costs by 1982.

The Tax Equity and Fiscal Responsibility Act of 1982, as amended by the Social Security Amendments of 1983, specified that enrollees' premiums in 1984 and 1985 would be allowed to increase to amounts necessary to produce premium income equal to 25 percent of program costs for elderly enrollees. (Disabled enrollees pay the same premiums even though the per capita cost of services to these enrollees is higher.) The Deficit Reduction Act of 1984 extended this provision for two calendar years (i.e., 1986 and 1987).

Explanation of provision.—The provision would extend for one additional year (calendar year 1988) the temporary provision of law under which enrollee premiums are to produce premium income equal to 25 percent of program costs for elderly enrollees.

Effective date.—Enactment.

MONTHLY PART B PREMIUMS

[CBO estimates]

	Calendar year—				
	1986	1987	1988	1989	1990
Current law	\$16.20	\$18.60	\$19.40	\$20.20	\$21.00
Provision	16.20	18.60	20.80	21.70	22.60

28. Correction of Charges for Certain Hospital-Based Physicians

Current law.—Combined billing arrangements (i.e., those under which the hospital was permitted to bill for all the services of certain hospital-based physicians and the hospital in turn paid the physician) were eliminated October 1, 1983. Carriers then established compensation-related customary charges (CRCC's) for those physicians for whom a customary charge profile was not available. The resulting payment levels were expected to be temporary. However, DEFRA froze the customary charges for all physicians for the 15-month period July 1, 1984–September 30, 1985. As described above, the Committee would continue the freeze for some of these physicians for an additional 12 months.

Explanation of provision.—The provision would provide for the recalculation of the CRCC's. For services rendered between October 1, 1985, and September 30, 1986, the customary charges of the physicians would be determined based on the physicians' actual charges made between April 1, 1984 and March 31, 1985. If such physicians had insufficient billings during that 12-month period, the calculation would be based on the first 3-month period beginning on or after February 1, 1985 for which sufficient billings are available. In either case, in order to put these physicians in the same position as other physicians, the actual charges will be deflated to September 1, 1984 levels in the case of physicians who were participating physicians during fiscal year 1985 or 1986; or to July 1982 in the case of physicians who did not participate in either year.

Effective date.—For services rendered on or after October 1, 1985, and before October 1, 1986.

29. Limit Payments for DME and Other Non-Physician Services

Current law.—Payments for durable medical equipment (DME), prosthetic devices, ambulance services, and certain other nonphysician services are generally made on the basis of reasonable charges. In the past, Medicare payment for DME was made for both rented and purchased items, depending on the beneficiary's decision to rent or purchase. Beginning February 1, 1985, the Secretary began implementing three methods for reimbursing DME under Medicare: lease purchase, lump sum purchase, and rental charges. In the case of inexpensive equipment (costing \$120 or less), Medicare will not pay more than if the equipment had been

bought. For equipment costing more than \$120, the carrier must determine which method is cost-effective based on the beneficiary's expected need for the equipment (as indicated on the physician's prescription) and reimburse accordingly. For items costing more than \$120, special provisions apply in the case of financial hardship.

Explanation of provision.—The provision would impose new reimbursement limits on nonphysician services paid on a reasonable charge basis under Part B other than DME that is lump-sum purchased or furnished under a lease-purchase agreement and independent clinical laboratory services. Purchased DME is exempted so that future customary and prevailing charge levels can be based on more complete and reliable data, i.e., billings between April 1984 and March 1985. During fiscal year 1986, Medicare customary and prevailing charges for services subject to the limits would be allowed to increase by 1 percent over the level in effect for the 15-month period beginning July 1, 1984. Thereafter, Medicare prevailing charges for these services and for lump-sum purchased or lease-purchased DME could rise no faster than the increase in the consumer price index.

Effective date.—October 1, 1985.

30. Deny Payments for Assistants at Surgery During Routine Cataract Operations

Current law.—Currently, Medicare covers assistants at surgery during routine cataract operations. Their services are considered reasonable and necessary if it is the generally accepted practice among ophthalmologists in the local community to use an assistant at surgery. Some Medicare carriers restrict coverage of assistants at surgery to cases where medical necessity is established.

Explanation of provision.—The provision would deny Medicare payment for assistants at surgery for routine cataract operations. The Secretary would be required to establish procedures by which the primary surgeon could request prior approval from the Peer Review Organization for the use of an assistant in cases where complicating medical conditions exist.

The assistant at surgery (or someone on his or her behalf) would be prohibited from billing the beneficiary for excluded services. In addition, the primary surgeon (or someone on his or her behalf) would be prohibited from including charges for the assistant in his or her bill for services. The bill would give the Secretary the authority to impose civil monetary penalties or assessments, or exclusion for up to 5 years from the Medicare program, or both, for violations of this provision.

The Secretary would be required, after consultation with the Prospective Payment Assessment Commission, to develop and report to Congress by April 1, 1986, recommendations and guidelines regarding other surgical procedures for which an assistant at surgery generally is not medically necessary and circumstances under which prior approval of an appropriate entity would be appropriate.

Effective date.—October 1, 1985.

31. Limit Reimbursement for Prosthetic Lenses

Current law.—Medicare Part B pays for prosthetic lenses (i.e., cataract contact lenses and eyeglasses) if determined to be medically necessary by the physician for aphakic patients. Generally, Part B carriers are authorized to pay for replacement of prosthetic lenses without a physician's order in cases of loss or irreparable damage and when supported by a physician's order in cases of a change in the patient's condition. Currently, there are no uniform limits on the number of replacements for which Medicare will provide reimbursement.

Physicians can bill Medicare for services related to cataract surgery in two ways: (1) a comprehensive service code covering the lenses, their fitting and evaluation, and short-term follow-up to assure their suitability; or (2) separate codes for the lenses and for the physician's services.

Explanation of provision.—The provision would limit Medicare reimbursement for lost or damaged prosthetic lenses as follows: (1) for cataract eyeglasses, one replacement each year; and (2) for cataract contact lenses, one original and two replacements per eye the first year after surgery and two replacements per eye each subsequent year. There would be no limit on replacements necessitated by changes in the patient's medical condition. The Secretary would be required to apply an "inherent reasonableness" test in determining reimbursement amounts for lenses and to determine separately the reasonable charge for the related professional service.

Effective date.—October 1, 1985. In applying the replacement schedule, there shall not be taken into account any cataract eyeglasses or contact lenses replaced before October 1, 1985.

32. Preventive Health Services Demonstrations

Current law.—Medicare, whose focus is primarily on covering health care costs associated with acute conditions, does not generally provide coverage for preventive health services.

Explanation of provision.—The provision would require the Secretary of HHS to fund at least five demonstrations of 4 years duration, under the auspices of schools of public health or preventive medicine departments of accredited medical schools, to determine whether and how it would be cost-effective to include preventive services as a Medicare benefit.

Services to be made available to beneficiaries would include health screenings, health risk appraisals, immunizations, counseling and instruction on such matters as diet and nutrition, reduction of stress, exercise, sleep regulation, prevention of alcohol and drug abuse and mental health disorders, self-care, and smoking cessation and reduction.

Within 3 years, the Secretary would be required to submit a report to Congress describing the demonstrations in progress. Within 5 years, the Secretary would be required to submit a final report that would evaluate the costs and benefits of providing such services and recommend whether specific preventive services should be included as a Medicare benefit.

Effective date.—Enactment.

33. Extend Prospective Payments for Ambulatory Surgery

Current law.—Medicare may pay for ambulatory (i.e., outpatient) surgical procedures performed in three different settings.

(a) *Ambulatory Surgical Center (ASC).*—The “Omnibus Reconciliation Act of 1980” authorized payments for surgical procedures, to be specified by the Secretary, performed in an ASC to be made on the basis of prospectively set rates. On August 5, 1982, the Department issued final regulations and an accompanying notice identifying four groups of surgical procedures and the payment amount for each group. The payment amounts and the list of procedures has not been updated.

The prospective payment rates do not include payments for physicians’ services, prosthetic devices, or laboratory services.

Under the 1980 legislation, the costs related to the use of an ASC were covered in full. The Congress waived the 20 percent copayment usually required of patients for such Part B services in order to foster greater use of ambulatory surgical centers as opposed to higher cost hospitals.

(b) *Hospital outpatient departments.*—Medicare payments for ambulatory surgery performed in a hospital outpatient department are made on the basis of reasonable costs. As a Part B service, a 20-percent copayment is required of the patient in connection with the costs related to the use of the facility.

(c) *Physician’s office.*—The “Omnibus Reconciliation Act of 1980” also authorized payments to be made to physicians for the use of their office facilities when covered ambulatory surgical procedures were performed there. However, the legislation has not been implemented because adequate utilization and quality control peer review, which is required by law, is not available for office-based surgery.

When surgery is performed in any of these three settings, Medicare reimburses 100 percent of the physician’s reasonable charge, provided the physician agrees to accept assignment, otherwise the 20-percent copayment is imposed on the beneficiary.

Explanation of provision.—The provision would extend the ASC prospective payment approach to hospital outpatient surgery for all procedures which the Secretary approves for the ASC; 150 are currently approved. The rates for ambulatory surgery in all settings would be increased to include the costs associated with a given procedure, including prosthetic devices and lab work. Professional fees would not be included. The provision specifies that the pass-through for direct graduate medical education and capital costs associated with the surgery that is now paid to hospitals would be continued. Further, separately calculated payment would be provided to take into account the costs of services provided by a Certified Registered Nurse Anesthetist (CRNA).

The Secretary would be required to update the present ASC prospective rates to reflect current costs. No rate could exceed the DRG payment rate for comparable inpatient surgery. The rates would be updated annually.

The provision would require the Secretary to have PRO’s review outpatient surgical procedures.

Finally, the provision would eliminate the current law provisions which waive copayments in connection with both the use of the facility and the physician's charge.

Effective date.—The provisions relating to the updating of payments and lists of procedures are effective January 1, 1986. Payment amounts for ambulatory procedures that are furnished in ASC's and physician's offices will be updated prior to January 1, 1986. Other provisions are effective October 1, 1985.

34. Extension of On Lok Waiver

Current law.—Section 222 of the Social Security Amendments of 1972, Section 402(a) of the Social Security Amendments of 1967, and Section 1115 of the Social Security Act provide the Secretary of HHS general authority to conduct experiments and demonstrations on Medicare and Medicaid alternative payment systems and benefits and to waive compliance with various program requirements in conducting these demonstrations. Under this authority, the Secretary approved waivers for the On Lok Community Care Organization for Dependent Adults, a demonstration project conducted from February 1979 to October 1983. P.L. 98-21 required the Secretary to approve waivers for a new 3-year, risk-sharing, capitated payment demonstration to be conducted by On Lok from November 1983 to November 1986.

Explanation of provision.—The provision would require the Secretary to extend Medicare waivers for the risk-sharing On Lok demonstration upon their expiration, and if the State of California applies for an extension of related Medicaid waivers, to approve the State's application. It also requires that waivers be extended on the same terms and conditions as applied to the original approval mandated under P.L. 98-21 (except that requirements for collection and evaluation of information for demonstration purposes should not apply) and that approval of waivers remain in effect until the Secretary finds that the applicant no longer complies with these terms and conditions.

Effective date.—Enactment.

35. Expand PROPAC Membership

Current law.—The Social Security Amendments of 1983 (P.L. 98-21), provided for the establishment of the Prospective Payment Assessment Commission (PROPAC) consisting of 15 members appointed by the Director of the Office of Technology Assessment, generally to serve for 3-year terms.

Explanation of provision.—The provision would expand PROPAC membership from 15 to 17 members.

Effective date.—Enactment.

36. Remove Restriction on Actuarial Opinion

Current law.—Annual reports required of the Board of Trustees on the financial status of the Social Security trust funds (including the Medicare trust funds) must include an actuarial opinion certifying that the assumptions and cost estimates used in the report are reasonable. According to provisions in the Social Security

Amendments of 1983 (P.L. 98-21), that certification may not refer to the economic assumptions underlying the trustees report.

Explanation of provision.—The provision would allow the actuarial comment on the economic assumptions underlying the trustee's report.

Effective date.—Enactment.

37. Extend GAO Reporting Date

Current law.—The Deficit Reduction Act of 1984 (DEFRA) required the General Accounting Office to study the following aspects of Medicare contracting for claims processing:

The ability of HCFA to manage competitive bidding and the relative costs of competitive arrangements compared with cost-based reimbursement;

The appropriateness of removing the provider nomination requirements in the statute;

Any disparities in costs and quality of claims processing among various intermediaries and carriers;

Whether the Secretary's standards for evaluating contractor costs are adequate and properly applied; and

Whether the Secretary's authority is sufficient to deal with inefficient intermediaries and carriers either through the contract negotiation and budget review process or through the process of termination or nonrenewal of contracts.

DEFRA required submission of the report to Congress within 12 months of enactment, i.e., by July 18, 1985.

Explanation of provision.—The provision would extend the reporting date to 18 months after the enactment of DEFRA (i.e. January 18, 1986) to allow the GAO to expand the scope of the study as requested by the committees of jurisdiction (i.e. Senate Committee on Finance, House Committee on Ways and Means, and House Committee on Energy and Commerce).

Effective date.—As if originally included in the Deficit Reduction Act of 1984.

38. Allow Greater HMO Membership on PRO Boards

Current law.—The Secretary must enter into contracts with organizations to provide utilization and quality control peer review of the health care services paid for under Medicare. The contractors are referred to as Peer Review Organizations (PRO's). An applicant whose governing body has more than one member who is affiliated with a health maintenance organization (HMO) is given secondary preference to physician-sponsored or physician-assisted entities when PRO contracts are awarded.

Explanation of provision.—The provision would allow PRO's with more than one HMO board member to qualify as a PRO on the same basis as other organizations.

Effective date.—Enactment.

39. Peer Review Organization Reimbursement

Current law.—Section 1866(a)(1)(F)(iii) of the Social Security Act specifies that Peer Review Organization reimbursement is to be set

at a level which reflects peer review rates established in fiscal year 1982 for both direct and administrative costs (adjusted for inflation). Section 1866(a)(1)(F)(iv) specifies that the aggregate reimbursement for a fiscal year may not be less than the aggregate amount expended in fiscal year 1982 (adjusted for inflation).

Explanation of provision.—The provision deletes section 1866(a)(1)(F)(iii) and substitutes fiscal year 1985 for fiscal year 1982 in clause (iv). Reimbursement shall be made to the organization on a monthly basis, with payments for any month being made not later than 15 days after the close of such month. The Committee is concerned that the current law provisions could be used to restrict PRO reimbursement and expects this change to remedy that concern.

Effective date.—Enactment.

40. Require PRO Review of Health Maintenance Organization Services

Current law.—Current law requires the Secretary of Health and Human Services to contract with Peer Review Organizations (PRO's) for the review of the medical necessity, quality, and appropriateness of services provided to Medicare beneficiaries. The PRO's are required to review some or all of the professional services provided under Medicare. Each PRO, in consultation with the Secretary, determines the types and kinds of cases over which it will exercise its review authority in order to most effectively meet its responsibilities.

On January 10, 1985, the Secretary published final regulations to implement the 1982 TEFRA health maintenance organizations (HMO's) and competitive medical plans (CMP's) contract provisions with Medicare. The final regulation includes a provision that requires HMO's and CMP's with contracts under Section 1876 to comply with the requirement for PRO review of services furnished to Medicare enrollees. The Committee understands that the Health Care Financing Administration and representatives of peer review organizations and of HMO's and CMP's have developed a system to undertake review activities.

Explanation of provision.—The provision would, among other things, require the Secretary to implement HMO/CMP peer review of Part A and Part B services under all TEFRA contracts and the Committee expects the Secretary to allocate sufficient funds to support this review program.

Effective date.—Enactment.

41. Substitute for PRO Review

Current law.—A Peer Review Organization (PRO) which has entered a contract with the Health Care Financing Administration (HCFA) has exclusive authority to review utilization and quality of services as specified under Title XI of the Social Security Act. The Secretary may terminate a PRO contract for nonperformance provided certain procedures are followed. These procedures require the Secretary to "provide the organization with an opportunity to provide data, interpretations of data, and other information pertinent to its performance under the contract." The data is to be reviewed

by a panel appointed by the Secretary and the findings submitted to the Secretary and made available to the organization. The Secretary may accept or not accept the panels' findings. The Secretary may, with the concurrence of the organization, modify the scope of the contract. The Secretary may terminate the contract upon 90 days after the panel has submitted a report or earlier if the organization so agrees. The law does not make provision for assigning review (or backlogged review) to another entity during termination proceedings. Thus, terminations can create a period of several months where no utilization and quality review is conducted.

Explanation of provision.—The provision would authorize the Secretary to assign review authority to another entity after the PRO has been notified of an intent to terminate its contract because the PRO is not performing effectively and prior to the time when a new PRO contract is awarded.

Effective date.—Enactment.

42. Authorize Peer Review Organizations To Deny Payment for Substandard Care

Current law.—Peer Review Organizations (PRO's) may review, subject to the provisions of their contracts, the professional activities of physicians, other practitioners and institutional and noninstitutional providers in rendering services to Medicare beneficiaries. The review is to focus on: (a) the medical necessity and reasonableness of care; (b) the quality of care; and (c) the appropriateness of the setting. The law specifies that the determinations of the PRO with respect to medical necessity reviews and reviews of the appropriateness of the setting are generally binding for purposes of determining whether benefits should be paid. Despite the fact that PRO's are required to conduct quality reviews, they are not authorized to deny payment for care of substandard quality.

Explanation of provision.—The provision would authorize PRO's to deny payment for care of substandard quality that is identified through criteria developed according to a plan approved by HCFA.

Effective date.—Enactment.

B. MEDICAID

1. Allow Comprehensive Benefits for Pregnant Women

Current law.—All States cover the “categorically needy” under their Medicaid programs. In general, these are persons receiving cash assistance under the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs. Beginning October 1, 1984, States are required to extend categorically needy protection to the following groups of persons meeting AFDC income and resources requirements: (a) first time pregnant women from medical verification of pregnancy (where such women would be eligible if the child were born); and (b) pregnant women in two-parent families where the principal breadwinner is unemployed.

The law provides that benefits furnished to a categorically needy person shall not “be less in amount, duration or scope than the medical assistance available to any other (categorically needy) individual.” Current law specifies a few exceptions to this requirement.

Explanation of provision.—The provision would allow States the option to waive the “comparability” requirement under Medicaid with respect to services provided to pregnant women. Under this authority, States would be permitted to provide more extensive prenatal care to pregnant women than is provided to other categorically needy individuals.

Effective date.—First calendar quarter following enactment.

2. Task Force on Technology-Dependent Children

Current law.—No provision.

Explanation of provision.—The provision would require the Secretary to establish within 6 months after enactment a task force concerning alternatives to institutional care for technology-dependent children. In addition, the provision would require the task force to submit, not later than two years after enactment of this Act, a final report to the Secretary and Congress on (1) barriers that prevent the provision of appropriate care in a home or community setting to technology-dependent children, and (2) recommended changes in the provision and financing of health care in private and public health care programs so as to provide home and community-based alternatives for these children.

Effective date.—Enactment.

3. Permit Hospice Care as an Optional Medicaid Service

Current law.—Current law does not authorize comprehensive hospice care as a covered service under Medicaid.

Explanation of provision.—The provision would allow States to cover hospice care as an optional Medicaid benefit. It defines this benefit by reference to Medicare’s hospice benefit: Hospice care

would include the services included under Medicare. Hospice programs would be required to meet Medicare's requirements for organization and operation and be public or nonprofit. The amount, duration, or scope of hospice services could not be less than benefits under Medicare. Hospice services could be provided to terminally ill individuals who have voluntarily elected to receive hospice care instead of certain other benefits. Voluntary election could be for a period or periods as the State may establish and need not to be the same election periods as specified in Medicare's benefit. Beneficiaries could revoke election of hospice. States could apply the same eligibility standards for patients receiving hospice care outside of institutions as they apply to institutionalized patients. Medicaid cost sharing rules would apply to hospice patients.

Effective date.—Enactment.

4. Extension of Texas Long-Term Care Waiver

Current law.—Section 1115 of the Social Security Act provides the Secretary of HHS general authority to conduct experiments and demonstrations under Medicaid and to waive program requirements in conducting these demonstrations. Under this authority, the Secretary has approved a waiver for the demonstration project, Modifications of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged, for the period January 1980 throughout December 1985.

Explanation of provision.—The provision would require the Secretary to extend through December 31, 1988, approval of the waiver for the demonstration project, Modifications of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged and to continue the approval on the same terms and conditions as applied to the project as of the date of enactment of this Act.

Effective date.—October 1, 1985.

5. Enhance Third-Party Liability Collections

Current law.—Medicaid is intended to be the payer of last resort, that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program.

Explanation of provision.—The provision would require the Secretary to issue regulations so that the States:

- a. collect sufficient information to identify third party liabilities,
- b. computer match information about the beneficiary with other data bases, as specified by the Secretary, and
- c. use that information to pursue collections according to a plan approved by the Secretary of Health and Human Services.

The regulations would also provide that the States be financially penalized for not collecting the required information or not following through with the agreed-on collection plan. The provision would also make disclosure of third party liability a condition of eligibility for Medicaid. The provision clarifies the responsibility of Medicaid recipients for copayments and deductibles when third

parties are liable for payments on their behalf. The provision would also clarify that Medicaid is the payer of last resort with respect to self-insured plans.

Effective date.—October 1, 1985.

6. Optional Targeted Case Management Services

Current law.—“Case management” is commonly understood to be a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a designated person or organization. Under current Medicaid law, case management is not included among the list of medical services which may be covered under a State’s Medicaid plan. However, States may include case management services under freedom-of-choice and home and community-based services waivers authorized under section 1915(b) and 1915(c) respectively. In addition, States may receive administrative funds under their Medicaid plans for certain case management activities (for example, preadmission screening) when offered to all Medicaid recipients in all areas of the State.

Explanation of provision.—The provision would modify current law to include case management among the list of medical services which may be covered under a State’s Medicaid plan and would allow States to target case management services to specific groups and/or specific areas within the State without obtaining a home and community based services waiver. The intent is to allow case management to be provided as an additional service. It is not the Committee’s intent that the States use case management solely to reduce program costs. It is the committee’s intent that the States may target any Medicaid group, including the nonelderly, under this provision.

Effective date.—October 1, 1985.

7. Modify Revaluation of Assets Provision

Current law.—Under section 2314 of the Deficit Reduction Act of 1984, the so-called “revaluation of assets” provision, Medicare payments to nursing homes may not be increased to reflect higher capital costs that result solely from the sale of such facilities. Capital costs recognized for reimbursement include depreciation, interest expense, and in the case of proprietary providers, return on equity. Capital-related costs to the new owner are to be based on the lesser of historical cost (the cost to the original owner), or the purchase price of the asset. Medicaid payments are subject to a similar limit, but applied on an aggregate statewide basis, rather than an individual facility basis.

Explanation of provision.—The provision would modify the Medicaid revaluation of assets provision to allow a State’s aggregate capital cost payments to nursing homes to reflect increases in their valuation due to changes in ownership. The revaluations, however, would be limited to the acquisition costs of the previous owner increased by 50 percent of the nursing home cost index published in the Dodge Construction Index or 50 percent of the CPI, whichever is lower and reduced by the previously allowed depreciation. The U.S. General Accounting Office would be required to study the effect of this provision on the frequency of sales of nursing homes

and, if the volume of sales changes, the effect of the change on reimbursement and quality of care.

Effective date.—October 1, 1985.

8. Modify Coverage Beginning Date

Current law.—Current law authorizes Medicaid coverage, at State option, for individuals who are in medical institutions but who have too much income to qualify for cash payments under the Supplemental Security Income Program. The income standard which a State applies to this optional coverage group cannot exceed 300 percent of the SSI benefit amount payable to an aged, blind or disabled, individual in his own home who has no other income or resources. A hospital or nursing home stay qualifies an individual for Medicaid eligibility under the special income rule. Implementing regulations (42 C.F.R. 722) specify that the State Medicaid agency shall apply the special income standard beginning with the first full calendar month of institutionalization. Thus, persons who might otherwise qualify for Federal matching payments for a portion of the month in which they are institutionalized are prevented from doing so based on the full calendar month test.

Explanation of provision.—The provision would substitute for the calendar month test a requirement that payment begin at the beginning of any 30 consecutive-day period of institutionalization.

Effective date.—October 1, 1985.

9. Extend Optional Coverage of Children

Current law.—Under current law, States are able to cover all, or reasonable categories of, poor children under age 18 or 19 or 20 or 21. These are known as "Ribicoff children." The Deficit Reduction Act required States, beginning October 1, 1984, to cover all children born on or after October 1, 1983, up to age 5, who meet AFDC income and resources requirements. The law required that coverage for this population group be phased in over a 5-year period starting with the youngest children. Federal matching is not available for children under age 5 born prior to October 1, 1983, unless the State extends coverage to all Ribicoff children.

Explanation of provision.—The provision would allow States to cover, and receive Federal matching funds for, all Ribicoff children under age 5 immediately if they so desire.

Effective date.—January 1, 1986.

10. Modify Overpayment Recovery Rules

Current law.—State Medicaid agencies are allowed to pay nursing homes and hospitals at interim rates until final rates are established. If the final rate is less than the interim rate, the institution was overpaid and the State is responsible for the collection of the "overpayment". The State must refund the Federal share of the overpayment to the Federal Government. Under current program administrative instructions the State must refund the Federal share immediately upon discovering the overpayment. Further, refunds must be made for all overpayments even where they are not collectable because the providers have gone into bankruptcy or

have gone out of business. These administrative instructions have been upheld by the courts.

Explanation of provision.—The provision would allow States up to sixty days (from the date of discovery) to recover overpayments from providers and refund the Federal share. The provision would provide that a State is not liable for the Federal share of overpayments which cannot be collected from bankrupt or out-of-business providers.

Effective date.—October 1, 1985.

11. Home and Community Based Services Waiver Extensions

Current law.—Section 1915(c) of the Social Security Act authorizes the Secretary of HHS to waive certain Medicaid requirements to allow States to provide a variety of home and community-based services to individuals who would otherwise require the level of care provided in a SNF or ICF whose cost could be reimbursed under the State's Medicaid plan. A home and community-based waiver is granted for an initial term of 3 years, and, upon the request of a State, can be renewed for additional three-year periods, unless the Secretary determines that certain assurances have not been met.

Explanation of provision.—The provision would require the Secretary to extend, for a period of one year at a minimum or five years at a maximum, any waiver that expires during the 12-month period beginning September 30, 1985, if the State requests an extension.

Effective date.—Enactment.

12. Home and Community Based Services Waiver Renewals

Current law.—A Medicaid home and community based services waiver is granted for an initial term of three years, and, upon the request of a State, can be renewed for additional three-year periods unless the Secretary determines that certain assurances have not been met.

Explanation of provision.—The provision would require the Secretary to renew home- and community-based services waivers for additional five-year periods.

Effective date.—September 30, 1986.

13. Coordinated Services Between MCH Block Grant Program and Home and Community-Based Services Waivers

Current law.—Section 1915(c) of the Medicaid law authorizes the Secretary of HHS to waive certain Medicaid requirements to allow States to provide a variety of home and community-based services to individuals who would otherwise require the level of care provided in a SNF or ICF the cost of which could be reimbursed under the State's Medicaid plan.

States are using this authority to provide home and community-based services to a number of groups of individuals, including children.

Title V of the Social Security Act authorizes grants to the States for a variety of maternal and child health services. This program is referred to as the Maternal and Child Health (MCH) Block Grant.

Explanation of provision.—The provision would require the State Medicaid agency, whenever appropriate, to enter into cooperative arrangements with the State agency administering the MCH Block Grant allotment received under Title V of the Social Security Act. These cooperative arrangements must provide that individuals under 18 who are eligible for home and community-based services; will be referred to the State agency administering the MCH Block Grant.

In addition, the State MCH agency would be required to assure: (1) the establishment of an individual service plan for the child; (2) the designation of a case manager to assist the family in carrying out the plan; and (3) the monitoring of the utilization, quality, and costs of services provided for appropriateness and reasonableness.

Effective date.—Enactment.

14. Moratorium on Penalties for Excessive Errors Under the Quality Control System

Current law.—The Medicaid quality control (QC) system was designed to reduce erroneous medical assistance payments by monitoring and improving the quality of eligibility determinations, third party liability activities, and claims processing. The Medicaid QC system is the basis for the imposition of fiscal sanctions against the States for erroneous payments in excess of error tolerance levels set in Federal law.

Explanation of provision.—The provision would provide for a two-year moratorium on the withholding of Federal funds under the AFDC quality control system and for a study of ways to improve that system. These provisions apply to the Medicaid QC system.

Effective date.—Enactment.

15. Broaden Range of Services Under Waiver Authority

Current law.—Section 1903(m) of the Social Security Act stipulates that States cannot contract on an at-risk basis with an entity which provides a certain number and type of services unless certain conditions are met. If any entity provides; (a) inpatient hospital services and any other mandatory Medicaid service (except rural health clinic services) or (b) any three mandatory services, that entity must meet the specified standards before a State can enter into a risk contract with it for the provision of Medicaid services. The "Omnibus Budget Reconciliation Act of 1981" (OBRA) authorized the Secretary to waive, under the newly established freedom-of-choice waiver authority, the requirements of Section 1903(m) of the Social Security Act. The "Tax Equity and Fiscal Responsibility Act of 1983" (TEFRA) rescinded the authority of the Secretary to waive the requirements of section 1903(m) of the Social Security Act.

Explanation of provision.—The provision would increase to five the number of mandatory services an entity may provide, if it does not provide inpatient hospital services, before it would be consid-

ered a health maintenance organization under Section 1903(m) of the Social Security Act. Entities providing fewer mandatory services could provide services under the freedom-of-choice waiver authority without being subject to the 1903(m) requirements. The States would continue to be required to obtain a waiver from the Secretary for such contracts.

Effective date.—Enactment.

16. Life Safety Code Recognition

Current law.—The Secretary of Health and Human Services may establish “standards of safety and sanitation” applicable to intermediate care facilities for the mentally retarded. Section 1861(j)(13) of the Social Security Act specifies that skilled nursing facilities must meet the safety and sanitation provisions of such edition (as specified by the Secretary in regulations) of the Life Safety Code of the National Fire Protection Association until she prescribes a later edition.

Explanation of provision.—The provision would direct the Secretary to recognize in regulations the 1985 Life Safety Code of the National Fire Protection Association until a later edition is issued.

Effective date.—Enactment.

17. Publication of ICF/MR Regulations

Current law.—Section 1905(c) of the Social Security Act authorizes optional Medicaid coverage for services to persons in intermediate care facilities (ICF’s). These facilities provide health-related care for individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide but do require care and services which can be made available only through institutional facilities. Section 1905(d) provides that the term “ICF services” may include services in an institution for individuals who are mentally retarded. These ICF/MR’s must meet such standards as may be required by the Secretary. These standards were originally published in 1974 (42 CFR 442 Subpart G).

Explanation of provision.—The provision would require the Secretary to publish, within 60 days of enactment, proposed revisions to the standards for intermediate care facilities for the mentally retarded (ICF/MR).

Effective date.—Enactment.

18. Eligibility of Community Health Centers

Current law.—States can contract with organizations to provide health care services to Medicaid beneficiaries on a prepaid capitated basis. Organizations eligible to enter into such contracts are, in general, limited to Health Maintenance Organizations (HMO’s) that are federally qualified under the provisions of Title XIII of the Public Health Service Act. Community Health Centers, primarily funded by the Public Health Service, and certain rural health care centers known as Appalachian Health Centers, funded under the Appalachian Regional Development Act, that had existed prior to June 30, 1976, are eligible to enter into contracts with States to

provide health care services to Medicaid beneficiaries on a prepaid, capitated basis as if they were federally qualified HMO's.

Explanation of provision.—The provision would allow certain Community Health Centers and Appalachian Health Centers established after June 30, 1976 to participate in Medicaid as if they were federally qualified HMO's. To be eligible, these centers must have received at least \$100,000 under the appropriate acts during each of the two years prior to the Medicaid contract period.

Effective date.—Enactment.

19. Annual Calculation of Medicaid FMAP

Current law.—Under the formula in current law, the Federal share of State medical vendor payments is inversely related to the per capita income of the State. The Federal matching rate, known as the Federal Medical Assistance Percentage (FMAP) is designed to provide a higher percentage of Federal matching to States with lower per capita incomes and a lower percentage of matching for States with higher per capita incomes. Under the formula, if a State's per capita income is equal to the national average, the Federal share would be 55 percent. The law establishes a minimum FMAP of 50 percent and a maximum of 83 percent (though the highest rate currently in effect is 78%).

The Secretary of HHS is required to promulgate the FMAP between October 1 and November 30 of each even-numbered year which will be in effect for the 2-year period beginning the following October. The percentages are based on the average per capita income of each State and the United States for the 3 most recent calendar years for which satisfactory data are available from the Department of Commerce.

The FMAP for the fiscal year 1986 and 1987 period is based on State per capita income for 1981-1983.

Explanation of provision.—The provision would provide that the FMAP would be recalculated annually rather than biannually beginning in fiscal year 1988.

Effective date.—Enactment.

20. Allow Sampling for Nursing Home Medical Review

Current law.—Current law requires that the care of 100 percent of the patients in a nursing home must be reviewed annually to evaluate the appropriateness and quality of care the nursing home provides.

Explanation of provision.—The provision would allow nursing home reviews to be based on a sample, but would require the Secretary to prescribe guidelines for drawing a statistically significant sample for the reviews.

Effective date.—Enactment.

21. Wisconsin Health Maintenance Organization Waiver

Current law.—Current law precludes Health Maintenance Organizations (HMO's) that have chosen not to become federally qualified under the provisions of Title XIII of the Public Health Service Act from participating in the lock-in provision of the Medicaid pro-

gram. The Secretary of Health and Human Services was granted the authority to waive the requirement for federal qualification in the Omnibus Reconciliation Act of 1981. This authority was subsequently limited by the Deficit Reduction Act of 1984 to organizations that are receiving, and had received in each of two years prior to contracting with Medicaid, grants of at least \$100,000 under the Migrant Health Center, Community Health Center, or Appalachian Regional Commission programs, and that had greater than 25 percent of their membership accounted for by non-Medicare/Medicaid enrollees.

Explanation of provision.—The provision would allow the Secretary to grant Wisconsin two years renewable waivers of the federal qualification requirement upon application by the State of Wisconsin.

Effective date.—Enactment.

22. Clarification of Medicaid Moratorium Under DEFRA

Current law.—Under the “Omnibus Budget Reconciliation Act of 1981” States were given certain flexibility in structuring their medically needy programs. They were allowed to limit coverage to certain categories of persons and to vary the scope of services offered. Changes were not made in the financial eligibility requirements. However, implementing regulations made changes in the pre-OBRA financial eligibility rules and allowed the States to impose more restrictive standards and methodologies. The “Tax Equity and Fiscal Responsibility Act of 1982” (TEFRA) amended the Medicaid statute to clarify that Congress did not intend to change the policies governing income and resource standards and methodologies for determining eligibility of the medically needy from those in effect prior to OBRA. The TEFRA provision specified that the methodology to be used in determining income and resource eligibility for the medically needy must be the same methodology used under the relevant cash assistance program. However, a strict interpretation of this provision by the Department led to unintended and in certain cases, undesirable consequences. The “Deficit Reduction Act of 1984” (DEFRA) established a moratorium period during which the Secretary is directed not to take any compliance, disallowance penalty or other regulatory action against a State because a State in determining eligibility for noncash Medicaid recipients is using an income or resource standard or methodology that is less restrictive than the applicable cash assistance standard or methodology. The Secretary was directed to report to Congress within 12 months of enactment on the impact on States and recipients of applying income and resource standards and methodologies under the cash assistance programs to noncash eligibles. The moratorium is to run from the date of enactment until 18 months after submission of the required report. DEFRA further specified that no provision of law could repeal or suspend the moratorium unless such provision specifically amended or repealed that provision.

In January, 1985, the Health Care Financing Administration issued a Medicaid Action Transmittal (85-1) to all State Medicaid agencies setting forth HCFA's interpretation of the moratorium

provision of the Deficit Reduction Act. The Transmittal concludes that the moratorium applies only where the "existing approved State plan" is or would be in violation of the requirement, as interpreted by HCFA, that the States apply the same methodology or standards to their non-cash assistance Medicaid beneficiaries as they apply to their cash assistance recipients. The Transmittal concludes, "Since the moratorium applies only where the existing approved State plan is or would be in violation of the provisions of section 1902(a)(10)(C)(i)(III) and since Medicaid eligibility quality control (MEQC) reviews are conducted against the approved State plan, the moratorium will have no effect on MEQC reviews or error rates for past or future periods."

This interpretation is inconsistent with the intent of Congress.

More recently, a related problem has come to the Committee's attention. When a Medicaid applicant or recipient who owns his own home is admitted to a hospital or nursing home, the value of the residence is disregarded in determining whether he is eligible for Medicaid provided he intends to return home. However, when it is established that the individual could never return home, the value of his residence becomes a resource that can increase his resources beyond the permitted level. In the past, Federal Medicaid policy gave such an individual time to dispose of the property if he was making a bona fide effort to do so. Proceeds from the eventual sale of the house can be used to finance the patient's institutional costs until he has reduced his resources to the allowable level and can again be eligible to receive Medicaid payments.

This policy has provided a reasonable period to determine whether it is realistic to expect a return home. It avoids requiring patients to give up their homes while there is still a chance that their stay will be temporary. Once it is determined that a return to home is no longer feasible, recipients are given enough time to sell their property at its reasonable market value rather than being forced to dispose of it quickly at what may be below-market value.

Recent interpretations of these policies would tend to force premature sale of the homes of institutionalized Medicaid applicants and recipients. For example, one interpretation would require the value of an unsold house to be counted as an available resource even though the applicant or recipient is making a bona fide effort to dispose of it. Another new policy would force premature sale of homes by some patients who still have reasonable expectations of returning home.

Explanation of provision.—The provision would clarify that the moratorium on the Secretary's sanction activities applies to State Medicaid plans, whether or not approved, as well as the operation or administration of a Medicaid program by a State agency pursuant to that State plan. It also applies to any amendments to, or other changes in, a State plan, regardless of when the amendment or other change came to the Secretary's attention, and regardless of whether the Secretary has approved, disapproved, acted upon, or not acted upon the amendment or change. It applies to all States, including those States operating plans pursuant to section 1902(f) of the Social Security Act (relating to special eligibility rules for aged, blind, and disabled individuals receiving Supplemental Secu-

rity Income). It applies to Medicaid eligibility and quality control reviews and error rates for past and future periods.

The provision would also restore for the duration of the moratorium the previous Medicaid policy governing the period when homeownership by an institutionalized individual is permitted and the period of time given for the sale of a home. The homeownership moratorium would apply for purposes of determining the eligibility of recipients and applicants who seek to qualify for Medicaid under the medically needy provisions, the special income standard (300 percent of the SSI payment standard) for individuals in medical care institutions, and other institutionalized individuals who could be covered as optional categorically needy persons.

Effective date.—Effective as if included in the original DEFRA provision.

23. Home and Community-Based Services Demonstrations

Current law.—Section 1915(c) of Medicaid law authorizes the Secretary of HHS to waive certain Medicaid requirements to allow States to provide a variety of home and community-based services to individuals who could otherwise require the level of care provided in a SNF or ICF the cost of which could be reimbursed under the State's Medicaid law.

In order to receive approval for a waiver, States must provide a number of assurances to the Secretary, including one requiring that the estimated average per capita expenditure for medical assistance under the program in any fiscal year not exceed the average per capita expenditure that the State reasonably estimates would have been incurred in that year if the waiver had not been granted.

Explanation of provision.—The provision would require the Secretary to conduct demonstrations in four States to determine whether and to what extent State controlled home and community-based services programs for elderly, disabled and developmentally disabled Medicaid recipients reduce expenditures for the: (a) society as a whole, (b) Federal government, and/or (c) States.

Within certain spending limits, the four States would be allowed to provide habilitative services not currently reimbursable under Medicaid or on care provided in small facilities not normally certifiable under Medicaid. All current quality of care standards and requirements would have to be met in the demonstrations. Demonstrations would be three years in duration. The Secretary would be required to select programmatically and demographically disparate States. The Secretary would also be required to evaluate the four State demonstrations. A preliminary report from this evaluation would be due during the third year of the demonstrations.

Effective date.—Enactment.

24. Participants Under Home and Community-Based Services Waivers

Current law.—Section 1915(c) of Medicaid law, authorizes the Secretary of HHS to waive certain Medicaid requirements to allow States to provide a variety of home and community-based services to individuals who would otherwise require the level of care provid-

ed in a SNF or ICF the cost of which could be reimbursed under the State's Medicaid plan.

Regulations require States in their applications to provide home and community-based services to describe the group or groups of individuals to whom services will be offered and to estimate the *unduplicated* number of recipients who will receive services in a given year. Program administrators have determined that individuals who receive services in a given year and who during that year die, enter a nursing home, or otherwise drop out of the home and community-based care program can not be replaced in that year with other individuals who would be eligible to receive such services. In the second year, however, these slots could be filled.

Explanation of provision.—The provision would amend the home and community-based waiver authority to specify that for waivers which contain a limit on the number of individuals who will receive home and community-based services, the State may substitute additional individuals to receive services to replace any individuals who die or become ineligible for services. The Committee wishes to emphasize that the intent of the home and community based waiver provision is not to reduce federal expenditures. The Committee believes that the waiver provisions should not be used as a vehicle to reduce federal expenditures.

Effective date.—Enactment.

25. Extension of Home Health Aide Demonstration in New Jersey

Current law.—The “Omnibus Reconciliation Act of 1980” authorized the Secretary to enter into agreements for the purpose of conducting demonstration projects to formally train AFDC recipients as homemaker-home health aides. These individuals could then be employed by public and nonprofit private agencies to provide supportive services to people, primarily the aged and disabled, who would reasonably be expected to require institutional care in the absence of these services. The bill authorized 90% Federal matching under the States’ Medicaid programs for the reasonable costs (less any related fees collected) of conducting the projects. The projects would be limited to a maximum of 4 years plus an additional period of up to 6 months for planning and development and a similar period for final evaluation and reporting.

Explanation of provision.—The provision would extend for one additional year at 50% Federal matching, the demonstration project in the State of New Jersey.

Effective date.—Enactment.

26. Correction Plans for Intermediate Care Facilities for the Mentally Retarded (ICF/MR)

Current law.—The Secretary has authority to conduct validation, or “look behind”, surveys to determine the validity of Medicaid certification actions taken by the designated State survey agency. Where the Secretary finds that a facility substantially fails to meet the requirements of participation in the Medicaid program, she is empowered to cancel the facility’s provider agreement.

As a result of these surveys, the Secretary has cancelled the provider agreements of several facilities—generally on the grounds

that the health and safety of residents were in immediate jeopardy—and accepted plans of corrections from many other facilities. Current law allows the State 30 days in which to file a plan of correction for the affected facility; once the plan has been accepted by the Secretary, the facility has 180 days in which to correct all deficiencies identified by the Federal survey team.

Explanation of provision.—The provision includes language which specifies the conditions under which a State may submit a plan of correction for a facility found to have non-life-threatening deficiencies. The language spells out the basic contents of the plan, including the conditions under which a State may include, as part of its correction plan, a phased reduction in the facility's population. The Secretary may allow a State up to 36 months to complete such a planned reduction in the number of facility residents, but only on the condition that the State agrees to achieve interim objectives, established at six-month intervals. The Secretary may allow the use of temporary staff during the phase-down period. Whether or not a State intends to reduce a facility's population as a part of its correction plan, the Committee expects that the Secretary will carefully monitor the State's progress in fulfilling its obligation under such a plan. If at any time during the period in which the deficiency correction plan is in effect, the Secretary finds that the State has substantially failed to meet its obligations under the plan, the Committee expects that prompt action will be taken to terminate the facility's provider agreement.

The Secretary should not approve a 36-month plan of correction involving a phased reduction in a facility's population unless there is evidence that adequate steps will be taken to improve the availability and quality of services to all residents, including those residents expected to remain in the facility during and subsequent to the phase-down period. Furthermore, to be approved, a plan of correction should demonstrate, to the satisfaction of the Secretary, that the facility will be in full compliance with all Federal standards no later than the end of the correction period.

In recognition of the fact that despite good faith efforts to execute its reduction plan, a State may fall behind in meeting its interim goals as set forth in the approved plan of correction, the Secretary shall withhold an amount of Federal financial participation equal to five (5) percent of the allowable Medicaid costs for all eligible facility residents for each month the State fails to meet its interim goals. The Committee believes that the proposed penalty will serve as a positive incentive for States to meet deadlines spelled out in their approved plans of correction and provide quality care.

Effective date.—Enactment.

C. MATERNAL AND CHILD HEALTH

1. Maternal and Child Health (MCH) Expenditures

Current law.—Under the MCH Block Grant, States must obligate a fiscal year's allotment within a two-year time frame. In other words, these funds must be expended by the States prior to the close of that second year.

Explanation of provision.—The provision would repeal the current law provision that requires States to obligate their MCH Block allotments within a two-year time frame. States would then have greater flexibility to spend their allotments as their specific needs determine.

Effective date.—Enactment.

2. MCH Terminology Change: "Children with Special Health Care Needs"

Current law.—The Maternal and Child Health Services Block Grant provides services and care for children who are crippled or who are suffering from conditions leading to crippling.

Explanation of provision.—This provision would change the term "crippled children" to "children with special health care needs" wherever the term "crippled children" appears in Title V, the Maternal and Child Health Block Grant.

Effective date.—Date of enactment.

D. SOCIAL SECURITY

1. Coverage of Senior Status Federal Judges

Current law.—

Federal judges are appointed for life. Once a judge qualifies for retirement, he continues to receive his annual pay, regardless of whether he chooses to continue on active duty in the judiciary. Prior to enactment of P.L. 98-21, Federal judges, like all Federal employees, were excluded from Social Security coverage so the question of Social Security taxes did not arise. Additionally, the amounts received by judges who had achieved senior (retired) status had been determined not to be wages for purposes of the earnings test.

The 1983 Social Security Amendments (Public Law 98-21) provided that the wages of all active Federal judges would be subject to Social Security taxes beginning January 1, 1984. This provision applied to both current and future judges. P.L. 98-21 also specifically provided that amounts received by judges who achieve senior (retired) status but who continue on active duty would be subject to Social Security taxes on so much of their pay as was attributable to periods when they were performing judicial services. Those earnings would also cause reductions in the judges' benefits under the social security retirement test. (Subsequently, P.L. 98-118 delayed the effective date of this provision until January 1, 1986.)

*Explanation of provision.—*For purposes of the Social Security Act, the provision would exclude the amounts received by Federal judges who meet the criteria for retirement on salary (e.g. age 65 with 15 years of service or age 70 with 10 years of service), retire, and perform active duty, from the definition of wages. The effect of this exclusion would be to exempt their pay from Social Security taxes and to preclude it from being counted for Social Security earnings test purposes.

*Effective date.—*Effective for services performed after December 31, 1983.

2. Social Security "Notch" Study

*Current law.—*Some workers who reach age 62 in 1979 (or later) and have their Social Security benefits determined under the computation provisions included in the 1977 Social Security amendments can get significantly lower monthly benefits than similar workers who reach age 62 in 1978 (or earlier), have similar earnings histories, retire at the same age and have their benefits computed under the old system. This difference in benefit amounts is commonly referred to as the "notch."

Because benefits are generally lower under the new system, a transitional provision was included in the 1977 amendments to

smooth the differences between benefits computed under the two systems in the early years. A worker who reaches age 62 in 1979-1983 gets a benefit figured under the transitional provision if the benefit is higher than the one figured under the new system. While the transitional provision lessens the extent of the benefit differential described above, it does not eliminate the differential.

Explanation of provision.—The Secretary of Health and Human Services would be directed to appoint a panel to study the Social Security “notch”. The panel is to study the extent of the benefit differential known as the “notch”, as well as the nature and desirability of actions for addressing this benefit differential. The report is to include estimates of the short- and long-range costs of such proposals. The panel’s report will be submitted to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives by December 15, 1986.

Effective date.—On enactment.

3. Recovery of Overpayments

Current law.—Under the Social Security Act, entitlement to Social Security benefits ends with the month before the month of death and eligibility for supplemental security income (SSI) benefits ends with the month of death. Under current reclamation procedures, benefits erroneously paid to a deceased individual by means of direct deposit are recovered by the Department of the Treasury from the financial organization which accepted the amounts for deposit in the deceased beneficiary’s account. In most cases, the financial organization debits the individual account to which the amounts were finally credited. When an individual account is debited, the financial organization is required to provide concurrent notice to any individuals shown as owners of the account.

Explanation of provision.—The amendment provides that when (1) a payment is made to a deceased individual by means of direct deposit; (2) such payment is credited by a financial organization to an account jointly owned by the deceased individual and another person; and (3) such other person is (a) entitled to a Social Security benefit based on the same wages and self-employment income as the deceased person for the month immediately preceding the month in which the deceased person died; or (b) such other person is the surviving spouse of the deceased person and was eligible for an SSI payment (or federally administered State supplement) as an eligible spouse (including either member of an eligible couple) in the month in which the deceased individual died; such payment shall be treated as an overpayment to the surviving individual.

Subjecting such payments to the overpayment recovery process, rather than the reclamation process, would extend certain due process rights, the right to request waiver of recovery of the overpayment and gradual recovery procedures to the surviving joint account owner who was receiving Social Security benefits based on the same earnings record as the deceased or who was the individual’s spouse and was receiving SSI benefits. Thus, their treatment would be analogous to the treatment of similarly situated beneficiaries who are overpaid for some other reason. This treatment

would minimize the confusion and financial hardship which the current reclamation procedures cause in these cases.

Effective date.—With respect to deaths of which the Secretary of Health and Human Services is first notified on or after the date of enactment.

4. Minor and Technical Changes

Current law.—The Committee approved a number of provisions to make minor improvements and necessary technical changes to title II of the Social Security Act.

Explanation of provisions.—Some of the provisions approved by the Committee result in minor extensions of benefit protection. Others correct unintended results of recent amendments to the Social Security Act, primarily the 1980 Disability Amendments and the Social Security Amendments of 1983.

1. *Demonstration Projects Involving the Disability Insurance Program.*—The Social Security Disability Amendments of 1980 directed the Secretary of Health and Human Services to develop and carry out experiments and demonstration projects to test the advantages and disadvantages of various ways to facilitate and encourage the return to employment of individuals who would otherwise remain dependent on Social Security Act disability benefits. The 1980 law specifically directed that these demonstration projects address such areas as alternative methods of treating the work activity of recipients, alterations in the trial work period and the medicare waiting period, earlier referral for rehabilitation, and greater use of employers and others to develop new forms of rehabilitation. A key element in conducting these demonstration projects is the authority for the Secretary to waive requirements of the Social Security Act related to the subject matter of the projects. A provision of the 1980 amendments calling for a final report within 5 years of the enactment of that statute has been interpreted as terminating the Secretary's authority to make such waivers. Without this authority, the Secretary would be unable to carry out the demonstration projects which were mandated by the 1980 amendments but have not yet been implemented. The requirements of the 1980 amendments as to the types of projects to be carried out remains unchanged. The provision extends the waiver authority for 5 years, and requires a final report to Congress by June 9, 1990.

2. *Disability Advisory Council.*—The Social Security Act requires an Advisory Council on Social Security to be appointed every 4 years, at the beginning of each Presidential term, and to report by January 1 of the second year after appointment. The provision establishes a special ad hoc Disability Advisory Council in lieu of the general council scheduled to be appointed in 1985. The ad hoc Council shall report to Congress by January 1, 1987.

3. *Taxation of Social Security Benefits Received by Citizens of U.S. Possessions.*—Under present law, citizens of American Samoa are treated as non-resident aliens and are subject to withholding of taxes from their social security benefits at a 15 percent rate. Citizens of other U.S. territories are exempt from the withholding requirement. The provision eliminates U.S. tax withholding on social

security payments to citizens of American Samoa, to make it consistent with the tax treatment of citizens of other U.S. possessions. This provision would apply to benefits received after December 31, 1983, in taxable years ending after such date.

4. *Dependency Test for Adopted Great-Grandchildren.*—Under present law, a grandchild (under age 18) of a social security beneficiary may be entitled to benefits if the child is adopted by and lives with the grandparent for at least 1 year before applying for benefits and received half his support from the beneficiary. The amendment would extend the provision to great-grandchildren of the beneficiary and would apply with respect to benefits for which application is filed after the date of enactment of this Act.

5. *Cease Publication of Annual Revisions in the Pre-1979 Benefit Tables.*—Under present law, the Secretary is required to publish the pre-1977 Amendments table of benefit amounts as revised by each general benefit increase. (This table applies only to those eligible for benefits before 1978 and the enactment of the Average Indexed Monthly Earnings provision.) The provision would eliminate the requirement to publish the revised tables, but would not affect the revisions themselves.

6. *Notification Formula Clarification.*—Under the 1983 Amendments, the Board of Trustees is required to notify Congress whenever it determines that the balance in any of the trust funds at the beginning of any calendar year may become less than 20 percent of expenditures. The provision clarifies the Congressional intent that the determination should utilize a measure of reserves which includes the taxes credited to the trust funds on the first day of each month.

7. *Extension of 15-Month Reentitlement Period for Childhood Disability Beneficiaries Subsequently Entitled.*—Under present law, disabled individuals who complete a 9-month trial work period and still have a disabling impairment, may be automatically reinstated to active benefit status during the next 15 months for any month in which their earnings fall below substantial gainful activity (SGA) level, currently \$300 per month. However, a person entitled to benefits as a disabled adult child who has used this provision once cannot subsequently be covered by it again. The provision extends the subsequent 15-month reentitlement periods to reentitled childhood disability beneficiaries. The provision would be effective December 1, 1980.

8. *Charging of Work Deductions Against Auxiliary Benefits in Disability Cases.*—Under present law, when a person receiving auxiliary benefits on the record of a disabled worker has earnings which exceed the exempt amount allowed under the earnings test, work deductions are imposed against the auxiliary worker's benefits which could be payable after any reduction for the family maximum limit. However, the amount withheld from the working individual is redistributed to others in the family so that the family continues to receive benefits up to the family maximum. A technical error in the 1980 provision uses the regular (retired) family maximum formula for computing the amount to be withheld from the working family member instead of the disability family maximum formula which is used to determine the amount actually payable to the entire family. The provision requires that the disability

family maximum limit would be used for computing the individual's deductions as well as for computing the total family entitlement. The provision would be effective with respect to benefits payable for months after December 1985.

9. *Perfecting Amendments to Disability Offset Provision.*—The 1981 Omnibus Budget Reconciliation Act expanded the social security disability offset (reduction in social security disability benefits due to receipt of other types of benefits) to include most governmental disability benefits paid to individuals. Previously, the offset was applicable only to workers' compensation payments. However, unclear wording led to confusion with regard to the continued application of the offset to certain workers' compensation benefits. Present law also treats State and local disability payments differently than similar Federal payments. The bill amends the present law to clarify that all disability benefits paid under a Federal or State workers' compensation law or plan would continue to be subject to the disability offset. Moreover, the provision clarifies that both Federal and State or local workers must have had substantially all their service covered by social security to be excluded from the disability offset.

10. *State Coverage Agreements.*—Under present law, coverage of State and local employees under social security is, in most cases, effective on the date that an agreement is mailed by the State to the Secretary of Health and Human Services. However, for workers paid on a fee basis and for those whose coverage is retroactive, the agreement becomes effective on the date it is signed by both parties, which may result in complications and loss of coverage for some employees. The provision would make all agreements and modifications of agreements effective on the date the agreement is mailed or delivered by other means to the Secretary.

11. *Effect of Early Delivery of Benefits.*—Under present law, when the normal delivery date for social security benefits (the third day of the month) falls on a Saturday, Sunday or legal holiday, checks must be delivered on the nearest preceding banking day. This may result in checks being delivered in the previous month. If this situation arises at the end of a year, it could cause distortion of year-end trust fund balances, possibly making them low enough to trigger the stabilizer provision, which could affect the amount of cost-of-living increases. This could also result in exaggerated beneficiary tax liability. The provision would eliminate these problems by providing that, for purposes of asset-expenditure ratio calculations and taxation of benefits, Social Security benefits delivered prior to their scheduled delivery date would be deemed to have been paid on the regular delivery date.

12. *Preservation of Benefit Status for Disabled Widows and Widowers.*—The Social Security Amendments of 1983 raised the amount of benefits for disabled widows and widowers aged 50 to 59, effective January 1984. As a result of the increase, some beneficiaries lost eligibility for Supplemental Security Income (SSI) and, consequently, Medicaid. The provision requires that those low-income widows and widowers who lost SSI eligibility because of the January 1984 disability benefit increase may file an application for protection with the State within 15 months after enactment and be deemed to be receiving SSI benefits for the purpose of medicaid eli-

gibility. The provision further directs the Secretary to inform the States of the identities of affected individuals, and States to notify such individuals, solicit their applications for medicaid coverage and process their applications promptly. Effective for months starting at least 2 months after enactment.

Effective date.—On enactment, unless otherwise noted.

E. SUPPLEMENTAL SECURITY INCOME

Modification of Pass-through Requirement

Current law.—The Supplemental Security Income (SSI) program provides for needy aged, blind, and disabled people a Federal income assurance level of \$325 per month for an individual and \$488 for a couple. Under a 1974 provision, these amounts are increased annually to offset inflation.

States, at their option, may provide supplemental assistance above these Federal levels, and the State payments may be made separately or included in the Federal SSI check. To prevent a situation where the Federal cost-of-living increase would simply be offset by a reduction in State benefits with no increase to the recipient, a pass-through requirement was adopted in 1976.

Under the 1976 law, States could comply with the pass-through requirement either by assuring that total State expenditures for SSI recipients did not decrease from one year to the next or by keeping the State benefit levels (the amount over and above the Federal level) at least as high as they were in December 1976.

In 1983, a one-time \$20 increase in the Federal levels (\$30 for couples) was enacted. The 1983 law required only a portion of this one-time increase to be passed through by the States, but also required that States use March 1983 rather than December 1976 as the base for determining whether their benefits had declined. The Senate had proposed the partial \$20 pass-through with a March 1983 base as an *additional* method of compliance, but the House version—which was enacted—eliminated the option of maintaining full December 1976 levels. As a result, States which had increased benefit levels after 1976 (but before March 1983) lost the right to reduce them back to a level at or above the December 1976 level. Due to this change, a State could be out of compliance because of a recent reduction in supplemental benefits even though, on an aggregate basis, the State had more than passed through the overall increase which has taken place in Federal benefits since 1976.

Explanation of provision.—The provision would follow the approach of the Senate bill in 1983 which would have retained as an alternative allowing States to meet the pass-through requirement by showing that their current benefit levels are at least as high as they were in December 1976. This means that, in the aggregate, they have passed through the total of all Federal benefit increases since 1976 including the full \$20 increase in 1983. The effect of the amendment is to permit the States to meet the pass-through requirements by using any method of doing so that was permissible under the statute prior to the 1983 amendments (in addition to the new method added by the 1983 amendments).

Effective date.—For months beginning after March 1983.

F. AID TO FAMILIES WITH DEPENDENT CHILDREN

1. Moratorium on Disallowances for Excessive AFDC and Medicaid Errors/Authorization of QC Study

Current law.—The Quality Control (QC) system was established to improve administration of the Aid to Families with Dependent Children (AFDC) program and the medicaid program by identifying errors and developing corrective actions to eliminate the errors. The QC system is the basis for the imposition of disallowances of Federal matching for erroneous payments by the States in excess of error tolerance levels set in Federal law.

Explanation of provision.—

1. No State AFDC or medicaid funds would be withheld prior to a date 2 years from the date of enactment.

2. Effective upon enactment, the Secretary and the National Academy of Sciences would conduct concurrent, independent studies of how best to operate a quality control system with a view towards obtaining information which will allow program managers to improve the quality of administration and which will provide reasonable data on the basis of which Federal funding may be withheld for States with excessive levels of erroneous payments.

3. It is expected that the independent studies will be exhaustive and may include such issues as the proper sampling procedures, error tolerance levels, the nature of the errors on which to base penalties, statistical estimating procedures, and the methods of reducing error. Additionally, the studies should review the findings of a report to be issued on this subject by the General Accounting Office. The study was requested by the Senate Committee on Governmental Affairs and will be released in November of 1985.

The studies would be due 1 year from the date of enactment. The quality control case review process would continue and data would be collected to generate error rates. Payment error rates would be computed but funds would not be withheld on that basis. The Committee intends that the Secretary have the authority to alter the quality control systems during the moratorium. Not later than 18 months after the date of enactment, the Secretary would be directed to publish regulations which would:

1. restructure the quality control system to the extent necessary and appropriate in the light of the studies (as determined by the Secretary);

2. provide, in the light of the studies, for criteria for adjusting the amount of disallowances which would be applicable for prior years so as to eliminate any which apparently would not have been required under the new quality control system.

In addition to issuing regulations, the Secretary could also propose legislative changes which might be necessary in order to implement modifications in the QC system which the Secretary finds appropriate in light of the studies.

No disallowances shall be imposed during the two-year moratorium. Not later than the start of the calendar quarter beginning 2 years from enactment, the Secretary would be required to begin operating the revised quality control system and to begin withholding under that system, including any withholding applicable for years prior to the institution of that system (subject to the adjustments described above).

The proposal would thus allow 1 year for the study, 6 months for publishing the regulations to implement the study, and at least 6 months for Congress to review those regulations and, if required, enact legislation directing any modifications in those regulations which Congress might find appropriate.

Effective date.—On enactment.

2. Counting Certain Payments to Indians as Income

Current law.—A 1973 law, as amended in 1982, generally provides that certain per capita distributions to Indian tribal members from Indian trust funds will be exempt from taxation and will not serve to prevent eligibility or reduce benefits under Federally funded programs. As an exception to this general rule, per capita payments in excess of \$2000 can be counted as income for Federally assisted programs. This \$2000 limit on the exclusion does not, however, apply to programs under the Social Security Act and it applies on the basis of the amount of each payment without regard to how many payments are made in a year or how many members of the same household receive payments.

Explanation of provision.—The Committee bill would change the \$2000 limit so that it would apply to Social Security Act programs as well as to other programs. In addition, under the Committee bill, the \$2000 limit on exclusions would apply to the aggregate of all per capita payments received in a year by all members of a family unit.

Effective date.—The amendment would be effective as of January 1, 1986.

3. Recovery of Excess Funding for Incomplete Automated Systems

Current law.—Under the Aid to Families with Dependent Children program, a highly favorable Federal matching rate of 90 percent is available for the development and installation of automated claims processing and information retrieval systems. To qualify these systems must be designed and developed in accordance with a planning document approved by the Secretary of Health and Human Services. Present law does not address the case where States receive Federal funding under this authority and then fail to implement the automated system according to the schedule provided for in the approved planning document.

Explanation of provision.—The Committee bill requires the Secretary to recover 40 percent of the amounts expended on automat-

ed systems from any State which fails to implement those systems by the implementation date called for in the approved planning document. The net effect of such a recovery would be to lower the Federal participation in such systems to the ordinary 50 percent matching rate which is available for all State administrative costs in operating the AFDC program. If the failure to meet the deadline occurs for reasons which the State cannot control, the Committee bill authorizes the Secretary to extend the deadline. Only funds received by the State for expenditures after the date of enactment of this bill would be subject to recovery under the provision.

Effective date.—The amendment would be effective on enactment.

G. FOSTER CARE AND ADOPTION ASSISTANCE

(Title IV-E)

Foster Care

1. Extension of Provisions Relating to Ceilings on Foster Care Expenditures

Current law.—Under the Aid to Families with Dependent Children (AFDC) foster care program, States are entitled to Federal matching funds based on the Medicaid matching rate for foster care maintenance payments for AFDC-eligible children.

The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) established a mandatory ceiling on Federal foster care maintenance payments for each of fiscal years 1981 through 1984 if appropriations for the child welfare services program reached a specified level. These provisions were subsequently extended through FY 1985 (P.L. 98-617). For each of fiscal years 1983-1985, this level was set at \$266 million. Each State's ceiling is based on previous years' funding levels and/or the State's under-18 population.

When operating under the mandatory ceiling States may transfer, under certain conditions, unused foster care funds to be used for child welfare services. In addition, if appropriations do not reach the specified trigger amount necessary for the mandatory ceiling, States may through FY 1985 choose to operate under a voluntary ceiling and transfer a certain portion of "unused" foster care funds (funds not expended for foster care under the foster care ceiling amount calculated) to their child welfare services program.

Explanation of provision.—The provision requiring a mandatory ceiling on foster care expenditures, when child welfare services appropriations made in advance reach the specified trigger level, would be extended through FY 1987. The formulas for calculating each State's allotment would also be extended. The trigger level would be continued at \$266 million for each of FY 1986 and 1987. The proposal would also extend through FY 1987 the methods of calculating each State's allotment and the provisions allowing States to opt to operate under a ceiling on foster care expenditures.

Effective date.—October 1, 1985.

2. Extension of Voluntary Placement Provisions

Current law.—The Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272) authorized Federal matching payments to be made under the AFDC foster care program for a limited period (originally through FY 1983) for children removed from the home under a voluntary placement agreement, when States meet specified protections and procedures. The provision was extended through FY 1985 (P.L. 98-118 and P.L. 98-617).

Explanation of provision.—The provision allowing for payments for children placed under a voluntary placement agreement would be extended through fiscal year 1987.

Effective date.—October 1, 1985.

3. Program to Prepare Older Foster Care Children for Independent Living

Current law.—Federal matching funds are provided under Title IV-E of the Social Security Act for assistance payments on behalf of children in foster care who, had they not been removed from their own homes, would be eligible to receive Aid to Families with Dependent Children (AFDC) Program benefits. In general, these payments end when the child reaches age 18. The title IV-E program covers only maintenance assistance (e.g. food and shelter costs). If States provide services to help older foster children prepare for independent living after they reach age 18, those services are not eligible for Federal matching under the foster care program. Such services must be funded either at State expense or by using funds from other programs such as the title XX block grant or the Child Welfare Services program.

Explanation of provision.—The Committee bill would establish a new grant program under which funds would be allocated to the States for the purpose of assisting older children in Federally funded foster care (i.e., those who had reached age 16) to prepare for independent living. Under the proposal, a total of \$1 million would be made available in each of fiscal years 1986 and 1987. These funds are authorized on an entitlement basis and would be allocated among the States according to the ratio which each State's foster care caseload bore to the national caseload in fiscal year 1984. (This determination would be made on the basis of the average number of children in Federally funded foster care.) No non-Federal matching would be required, but States would not be allowed to use funds to replace other funds which are available for the same purposes. If a State does not apply for its share of the funds, the unused amounts would be reallocated to States needing additional funds as determined by the Secretary of Health and Human Services.

The Committee bill authorizes the funds granted under the program to be used for any of a variety of services, including:

- Services aimed at enabling participants to complete high school or take part in vocational training;
- Training in daily living skills (budgeting, career planning, etc.);
- Counselling;
- Coordination of other services;
- Outreach activities; and
- The development of individualized plans for the transition to independent living.

The Committee bill also modifies the title IV-E foster care statute to add a requirement that the case plan for each child in foster care must, where appropriate, include a description of the programs and services which will help prepare the child for the transition from foster care to independent living.

The objective of the Committee provision is to assist States in establishing or strengthening programs which will help the estimated 20,000 older children now in Federally funded foster care to successfully make the transition from public assistance to a life of independence. Such evidence as exists indicates that such children too often fail to achieve independence with the result that they end up in shelters for the homeless, on public assistance, or in correctional facilities.

The program proposed by the Committee would expire on September 30, 1987. By March 1, 1987 each State would be required to submit a report on its use of the funds and the extent to which they succeeded in accomplishing the purposes of the program. By July 1, 1987 the Secretary of Health and Human Services would be required, using these State reports, to present Congress with a description and evaluation of the program along with her recommendations as to the necessity for providing further payments in subsequent years.

Effective date.—Except as noted, the provision would be effective upon enactment.

4. Adoption Assistance

Current law.—Federal matching (at the Medicaid matching rate) is available under title IV-E of the Social Security Act for State adoption assistance payments on behalf of children who, prior to their adoption, had been members of AFDC-eligible families or who were SSI recipients. In order to qualify for Federal funding, the adoption assistance payments must be based on a finding that the child has special needs and that because of those special needs it is reasonable to conclude that the child could not be placed with the adoptive parents unless the adoption assistance is provided. (Special needs include such factors as the child's ethnic background, membership in a minority group, age, physical, mental, or emotional handicap or other medical condition, or the need to place the child with other members of the sibling group.)

Children for whom Federally funded adoption assistance payments are being made are also eligible for Medicaid. In cases where the major barrier to adoption is the need for medical assistance, some States now make token payments (e.g. \$1 per month) of cash adoption assistance in order to qualify the child for Medicaid.

In cases where a child qualifies for Medicaid on the basis that he is a recipient of Federally funded adoption assistance, the State which entered into the adoption assistance agreement is responsible for providing the Medicaid coverage. This is true even if the child and adoptive parents reside in a different State.

Federal matching for adoption assistance payments and eligibility for Medicaid based on adoption assistance is available only from the point at which the adoption takes place (or at which there is at least an interlocutory decree issued). Children placed with adoptive parents prior to the issuance of a final or interlocutory decree of adoption retain eligibility for Medicaid if IV-E foster care payments continue to be made on behalf of the child to the adopting parents, but if such payments were not made there could be a gap in Medicaid eligibility until the adoption decree is issued.

Explanation of provision.—The Committee bill proposes three modifications in the adoption assistance program in order to make Medicaid more readily available to qualified children.

Under the Committee provision, States would no longer be required to make token cash payments in order to provide Medicaid coverage. Any child who meets the eligibility requirements of title IV-E will be eligible for Medicaid provided that an adoption assistance agreement is in effect even if no cash assistance payments are provided for or being paid under that agreement. This change is designed to eliminate the unnecessary burden of making the token cash payment. It does not otherwise change the eligibility requirements of current law nor is it intended to imply that adoption assistance in the form of Medicaid should be routinely granted in all cases. States retain the responsibility of current law for determining that the child has a special need on the basis of which it can reasonably be assumed that the adoption could not take place without adoption assistance. Where the adoption assistance takes the form of Medicaid only, this would typically involve a significant handicap or other medical condition. As under present law, there would have to be an adoption assistance agreement, and that agreement can provide for readjustments in adoption assistance in the light of changing circumstances.

The Committee provision also permits Medicaid eligibility to be established as soon as the child is placed with the adoptive parents provided that an adoption assistance agreement meeting the requirements of the Adoption Assistance Program has been entered into. Thus, Medicaid eligibility would be available prior to the issuance of a final or interlocutory adoption decree.

The third change made by the Committee provision would make the State of the child's residence responsible for providing Medicaid coverage even if the adoption assistance agreement was entered into with a different State. This change is necessary because providers of medical services may be unfamiliar with and, therefore, reluctant to honor Medicaid coverage from other States.

Effective date.—October 1, 1985.

H. UNEMPLOYMENT COMPENSATION

1. Recovery of Overpayments

Current law.—When a State finds that it has made an overpayment of unemployment benefits, it may (after observing appropriate procedural safeguards) collect that overpayment by withholding a subsequent unemployment benefit due to the same individual.

This procedure, however, only is permitted when both the incorrect payment and the withheld payment are funded from the State's own unemployment trust fund. In some circumstances, unemployed workers receive benefits which are paid by the same State agency and appear to the worker as though they were the same type of unemployment benefit but are funded from different sources. This can occur, for example, when a worker moves from one State to another and receives some benefits from the State he moved from. It also happens when a worker's entitlement is extended by reason of trade adjustment assistance or other Federally financed unemployment programs.

Explanation of provision.—Under the Committee provision, a reciprocal withholding of overpaid unemployment benefits regardless of the funding source would be allowed. The same procedural safeguards would be required, but an overpayment of State benefits could be recovered by withholding from subsequent Federally-funded benefits if the State also agreed that it would recover incorrect Federal benefits by withholding from subsequent State benefits. Similarly, States would be allowed to withhold benefits payable under their program to recover payments of benefits incorrectly made to the same individual by other States. The implementation of this provision would be at the option of each State.

Effective date.—October 1, 1985.

Fifth, with respect to the purchase of inventory stock, the provisions in the bill: (1) require the flue-cured association to offer to sell its stocks from the 1976 through 1984 crops at the base prices in effect on the date of the offer, reduced by 90 percent for tobacco from the 1976 through 1981 crops and 10 percent for tobacco from the 1982 through 1984 crops; (2) require the burley associations to offer to sell their stocks from the 1982 and 1984 crops at the base price in effect on July 1, 1985, for the 1982 crop and at the associations' costs on the date of enactment of the bill for the 1984 crop; (3) require the Commodity Credit Corporation to take title to the 1983 crop burley tobacco held by the associations by calling the loans on such tobacco. Such tobacco would then be offered for sale on such terms and conditions as the Corporation deems appropriate. Any stocks not sold within two years after the loans are called may be offered for sale at the associations' costs on the date the loans are called, reduced by 90 percent; (4) authorize cigarette manufacturers to purchase the inventories as specified above over an eight-year period in the case of flue-cured tobacco and a five-year period in the case of burley tobacco. Each manufacturer would purchase a percentage of the stocks at least equal to the respective manufacturer's percentage of the total net cigarettes manufactured for use during a previous 12-month period as determined by the Secretary of Agriculture based on monthly reports submitted by manufacturers to the Department of the Treasury; and (5) require approval of each purchase agreement by the Secretary of Agriculture.

In addition, the provisions in the bill require the Secretary of Agriculture to conduct a study of the tobacco grading system and of the feasibility of establishing grades that would designate disaster crops, with authority for the Secretary to adjust the price support level for such grades. Further, they require a report to the House and Senate agriculture committees on the study within 120 days after enactment of the bill and administrative action to implement, before the opening of the 1986 flue-cured marketing season, the study recommendations that can be implemented by the Secretary.

Lastly, this bill authorizes the investment of fees and charges collected under the Tobacco Inspection Act. Any income realized from such investment would be used to pay the expenses of the Secretary of Agriculture in providing services under that Act.

Effective date.—The provisions would be effective upon enactment.

12. Medicare Coverage of State and Local Governmental Employment

Present law.—Under the Old Age, Survivors, and Disability Insurance program (commonly referred to as social security) and the Hospital Insurance program (commonly referred to as Medicare), coverage for State and local government employees is optional. An election for coverage under the Social Security Act includes both programs. A State controls the option for itself and its subdivisions; however, most often State governments allow their political subdivisions to make their own choices.

When elected, coverage is provided on a group basis through agreements between the State and the Secretary of Health and Human Services. Coverage can be provided even when the State or local government already has a retirement system in place. When there is no retirement system in place, the State or local government entity, not the employees, has the option to choose social security. However, if there is a system already in place, then the Governor or a designee must conduct a referendum of the employees involved.

Until April 1983, the law permitted the termination of coverage for employees covered under an agreement, if the State or local entity (through the State) had given two-years' advance notice. This provision, however, was repealed in the Social Security Amendments of 1983.

Reasons for change.—Individuals who have worked in State and local government employment that is excluded from social security coverage often acquire insured status and thus still may qualify for social security and Medicare benefits. They qualify as a result of work performed in other employment covered under the program or through the entitlement of a spouse. By and large, individuals who qualify after having worked in excluded State and local government employment have contributed significantly less in social security FICA taxes than others and who become entitled to benefits who have had comparable lifetime earnings. They therefore represent a financial drain on the system, and especially on the Medicare hospital insurance program.

Unlike monthly social security benefits, where minimal covered earnings and tax contributions result in minimal benefit amounts, entitlement to Medicare is entitlement for the full range of benefits. The benefits are the same regardless of whether the insured worker has made significant tax contributions over his or her working lifetime or whether the individual has qualified with the minimum number of quarters of coverage. The committee believes that this anomaly should be corrected.

Explanation of provision.—The provision extends Hospital Insurance (Medicare) coverage to current and new employees of State and local governments. The employers and their employees will become liable for the hospital insurance portion of the FICA tax, which is to be collected as in the case of a private employer, and the employees will earn credit toward Medicare eligibility based on their covered earnings. Mandatory coverage is extended only for Medicare and only for employment not otherwise covered under voluntary State coverage agreements.

Under the provision, State and local government employees who perform service during and before October 1986, would be given credit toward Medicare eligibility for past State and local government employment.

The provision also permits individuals who have worked for State and local governments to obtain Medicare benefits if they file and meet the insured status and other disability eligibility requirements of the social security disability cash benefits program, even though no such cash benefits would otherwise be payable. The Medicare application would be treated as an application for disability benefits (for purposes of determining eligibility to Medicare).

Effective date.—The provision is effective with respect to service performed after September 30, 1986, by employees of a State or local government who would not otherwise be covered under social security and Medicare on the basis of voluntary agreements.

13. Railroad Unemployment Repayment Tax

Present law.—Present law provides a railroad unemployment compensation program that is separate from and different than the regular Federal-State unemployment compensation system. Most workers in other industries are covered under the Federal-State unemployment compensation system.

The Railroad Unemployment Insurance (RRUI) program is administered by the Railroad Retirement Board (RRB), which collects the unemployment taxes directly from rail employers. Legislation enacted in 1959 provided the Railroad Unemployment Insurance Account with the authority to borrow from the Railroad Retirement Account when funds in the RRUI Account are not sufficient to meet benefit payments. This borrowing authority expires September 30, 1985. On that date, the outstanding debt to the retirement account is estimated to be \$783 million, of which \$526 million is principal and \$257 million is accumulated interest.

There is no automatic mechanism in the law to repay loans from the retirement account as they occur. Loans are repaid out of basic contributions to the unemployment account when the Railroad Retirement Board determines that there are sufficient funds in the unemployment account to make a repayment.

The Railroad Retirement Solvency Act of 1983 established a repayment tax scheduled to begin on July 1, 1986 and to expire on September 30, 1990. The tax rate will begin at 2.0 percent and increase by 0.3 percentage points a year up to a maximum of 3.2 percent in 1990. The tax is scheduled to expire on September 30, 1990. The tax is paid on the first \$7,000 in wages paid annually to a rail employee.

Reasons for change.—The loan repayment tax contained in the 1983 Railroad Retirement Solvency Act is not sufficient to repay the loans made to the Railroad Unemployment Insurance Account and to meet current and projected unemployment insurance benefit payments. The committee believes that an increase in the repayment tax, combined with a surcharge on new borrowing and a temporary one percent diversion of railroad retirement taxes to the Railroad Unemployment Account, will help avert an impending cash-flow crisis and strengthen the system's financial condition in the long run.

Explanation of provision.—The loan repayment tax, scheduled to begin on July 1, 1986 at a 2 percent rate with increases of 0.3% a year, is increased under the bill as follows:

Explanation of provision.—The bill terminates, as of September 30, 1986, the authorization under Code section 9501(c) of appropriations to the Black Lung Disability Trust Fund, as repayable advances, of such sums as from time to time are necessary to make the expenditures described in section 9501(d). Thus, no advance out of general revenues is to be made to the Trust Fund after September 30, 1986. Under the provision, the Trust Fund may not borrow prior to October 1, 1986 amounts to be used to make expenditures after September 30, 1986 or during post-1986 years.

The provision does not affect the automatic appropriation to the Trust Fund of amounts equal to the revenues collected from the coal excise tax and from certain excise taxes applicable with respect to black lung benefit trusts, either before or after October 1, 1986.

Effective date.—The provision is effective on the date of enactment. The section 9501(c) authorization would terminate as of September 30, 1986.

15. Certain Permanent Exemptions From the Federal Unemployment Tax Act

a. Remuneration paid to certain fishing boat crew members

Present law.—For purposes of social security taxes and income tax withholding, members of the crew on a boat in a fishing operation engaged in catching fish or other forms of aquatic animal life are considered to be self-employed if (1) their remuneration is a share of the boat's catch (or cash proceeds from the sale of a share of the catch and no other cash remuneration is provided), (2) their share depends on the amount of the boat's catch, and (3) the crew of the boat normally is made up of fewer than ten individuals. If these requirements are met, remuneration paid to these crew members is exempt from the Federal Insurance Contributions Act (FICA) tax and income tax withholding, and is subject to the Self-Employment Contributions Act (SECA) tax (Code secs. 3121(b)(20), 3401(a)(17), and 1402(c)(2)(F)).

Prior to the Economic Recovery Tax Act of 1981 (ERTA), remuneration paid to fishing boat crew members generally was exempt from tax under the Federal Unemployment Tax Act (FUTA), except that the exemption did not apply with respect to the services performed in connection with catching halibut or salmon for commercial purposes or services performed on a vessel of more than ten net tons (sec. 3306(c)(17)).

Section 822 of ERTA amended the definition of employment for purposes of FUTA taxes to exempt from FUTA taxes remuneration paid during 1981 to fishing boat crew members who were treated as self-employed for social security tax purposes and thus exempt from FICA (sec. 3306(c)(18)). Section 203 of the Miscellaneous Revenue Act of 1982 (P.L. 97-362) amended ERTA to provide that the exemption from FUTA taxes also was effective for remuneration paid in 1982.

Section 1074 of the Deficit Reduction Act of 1984 (P.L. 98-369) extended the exemption from FUTA for remuneration paid to fishing boat crew members who are exempt from FICA to remuneration paid in 1983 and 1984.

Reasons for change.—For reasons of simplicity and administrative convenience, the committee believes that fishing boat crew members who are treated as self-employed for purposes of the social security and income tax withholding should also be treated as self-employed for purposes of the unemployment tax. The committee believes that experience with this FUTA exemption since 1981 supports making the exemption permanent.

Explanation of provision.—The FUTA exemption relating to remuneration paid to certain fishing boat crew members, first enacted in section 822(b) of ERTA, is made permanent. Therefore, fishing boat crew members who are treated as self-employed for social security tax and income tax purposes are also to be treated as self-employed for purposes of the Federal Unemployment Tax Act. The bill also provides that spouses or children employed by such a fishing boat crew member (who is their spouse or parent) are not subject to the SECA tax.

Effective date.—The amendments made by the provision apply to remuneration paid after December 31, 1980.

b. Remuneration paid to certain camp counselors

Prior law.—In section 276(b) of the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), the Congress enacted a one-year FUTA exemption for remuneration paid to full-time students for employment by certain summer camps.

Reasons for change.—The committee believes that work performed by a full-time student in a summer camp does not involve the kind of employment relationship that should be covered by the unemployment insurance system. Therefore, the committee believes that wages paid for such employment should not be taxable under the Federal unemployment compensation law.

Explanation of provision.—The exemption from FUTA set forth in section 276(b) of P.L. 97-248 is reinstated on a permanent basis.

Effective date.—The provision applies to remuneration paid after September 19, 1985.

c. Remuneration for services of certain nonresident farmworkers

Present law.—FUTA generally applies to remuneration paid by farm operators who employ 10 or more agricultural workers in 20 weeks, or have a quarterly payroll for agricultural services of at least \$20,000. However, an exemption applies for wages paid for agricultural labor performed by aliens admitted to the United States pursuant to sections 214(c) and 101(a)(15)(H) of the Immigration and Nationality Act (Code sec. 3306(c)(1)(B)). This exemption from FUTA is scheduled to expire on December 31, 1985.

Reasons for change.—Sections 214(c) and 101(a)(15)(H) of the Immigration and Nationality Act pertain to residents of foreign countries who do not intend to abandon such residency and who are admitted to the United States to work for a temporary period of time during peak agricultural crop seasons. They are admitted only after the Secretary of Labor has determined and certified to the Secretary of State and to the Attorney General that there are not sufficient workers in the United States who are available to do the specific work the nonresident workers are admitted to perform. These farmworkers return to their countries and, therefore, are not able to collect unemployment compensation to which they might be entitled as a result of their employment in the United States. Ac-

cordingly, the committee believes that remuneration paid to such workers should not be subject to unemployment taxes.

Explanation of provision.—The bill makes permanent the FUTA exemption in Code section 3306(c)(1)(B) for remuneration paid to certain alien farm workers.

Effective date.—The provision is effective on enactment.

16. Internal Revenue Service Budget

Present law.—The Internal Revenue Service (IRS) is responsible for administering and enforcing the Federal tax laws. More than 95 percent of total Federal budget receipts are derived from the tax laws as administered by the IRS.

For fiscal year 1986, the Administration proposed 86,489 staff positions for the IRS and a total budget of \$3.5 billion. This was a decrease of 1,254 staff positions and \$30.4 million from the fiscal year 1985 appropriation (including requested amounts).

Reasons for change.—The committee is concerned that the Administration's budget proposal would not provide sufficient resources for the IRS to accomplish this vital role in raising Federal revenues. The committee believes that it is appropriate to increase budget receipts by collecting taxes that are properly due under present law, rather than raising taxes.

Explanation of provision.—The bill authorizes appropriations of \$46.5 million for the IRS for fiscal years 1986, 1987 and 1988, in addition to any other amounts authorized to be appropriated to the IRS for those fiscal years. This would permit the IRS to hire an additional 1,550 agents and examination employees, so as to provide sufficient improved enforcement to increase revenues by \$2 billion over fiscal years 1986–1988.

17. Limitation on Issuance of U.S. Bonds

Present law.—Obligations of the United States are defined as bonds if they have a maturity when issued that is longer than 10 years. The rate of interest that may be paid on a bond may not exceed 4-1/4 percent, except that up to \$200 billion in outstanding bonds with rates of interest above 4-1/4 percent may be issued to the public. The \$200 billion ceiling was enacted on May 25, 1984. The exception for a specified amount of bonds—initially \$10 billion—was enacted in 1971, and it applied to all bonds with rates above the ceiling. An amendment in 1973 applied the limitation only to bonds held by the public, i.e., holdings of Federal agencies and the Federal Reserve Banks were not included.

Reasons for change.—The Treasury Department has used almost all its current authority to issue \$200 billion in bonds with interest rates above 4 1/4 percent. The remaining authority is expected to be exhausted with bonds issued during the first quarter of 1986.

The Treasury Department has requested an additional \$50 billion in authority at this time so that it may plan the amount and timing of bond issues for the next several quarters. In addition, participants in the bond market also would be able to do longer-run planning. The ability to plan sales and purchases of the bonds reasonably far into the future is believed to contribute to a more stable bond market and lower borrowing costs.

Subtitle A--Medicare

Section 701. Rate of Increase in Payments for Inpatient Hospital Services. The increase in the DRG rates for PPS hospitals on October 1, 1985 is fixed at 0.5 percent. The increases on October 1, 1986 and October 1, 1987 are limited to the HCFA market basket. Although the Administration has issued regulations to freeze DRG rates during fiscal year 1986, the baseline assumes a 5.6 percent increase. We estimate this bill would cost an additional \$165 million in fiscal year 1986 when compared with the proposed regulations.

Section 703. Payments to Hospitals for Indirect Costs of Medical Education. The method of payment to hospitals for the indirect costs of teaching programs is reduced under this section. The indirect teaching adjustment is reduced to 7.7 percent beginning October 1, 1985. After October 1, 1987, the adjustment would be 8.7 percent. Finally, residents excluded from the direct medical education payments would also be excluded from the intern and resident to bed ratio (IRR) used in the calculation of the indirect medical education adjustment.

Section 705. Payments for Hospitals Which Have a Disproportionate Share of Low-Income Patients. A total of \$760 million would go to hospitals serving a disproportionate share of low-income elderly patients during 1986 and 1987. Of this cost, only \$400 million is reflected in the total for Section 705. The remaining \$360 million is attributed to a reduction in the indirect teaching adjustment from 8.7 percent to 7.7 percent during 1986 and 1987.

Section 706. Payments to Hospitals for Direct Costs of Medical Education. Under this proposal, Medicare's direct medical education payments would be frozen for one year and the direct costs associated with certain residents would be disallowed. The savings expected from this section were reduced by \$56 million during 1986-88 to reflect Medicare Part B billings needed to replace patient care activities for 25 percent of subspecialty fellows. Other nonreimbursable residents are assumed to remain in their residency programs, and hence there would be no increase in Medicare Part B billings. This estimate also assumes that 25 percent of the residents who graduated from non-approved schools would fall under the provision for the slower payment denial transition. Finally, the estimate assumes that exempt geriatric fellowships would increase by 100 each year starting in fiscal year 1987.

Section 710. Indirect Teaching Adjustment Related to Independent Clinic Activities. This section clarifies the method for calculating indirect teaching adjustments for Mayo Clinic affiliated hospitals. As a result payments to those hospitals are increased by \$3 million during 1986 through 1988.

Section 717. Extension of Working Aged Provisions. Under current law, workers aged 65-69 years must be offered the same health coverage as younger employees. Similarly, employee spouses aged 65-69, must be offered the same coverage as other spouses. For these workers and spouses, Medicare becomes a secondary payer, reimbursing only to the extent that Medicare is more generous than private insurance. Under

current law, workers and spouses 70 and older have Medicare as their primary payer with employers providing secondary coverage through a "medigap" policy. Section 717 extends the working aged provisions of the Social Security Act to workers 70 years or older and their spouses. Three types of individuals are included in this provision: workers 70 or older, spouses over 65 of workers 70 or older, and spouses over 70 of workers under 65. By making Medicare a secondary payer for these workers and spouses, Medicare outlays would be reduced by an estimated \$990 million during the period 1986 to 1988. The CBO estimate is based on an analysis of elderly workers from the Current Population Survey.

Section 720. Coverage of Respiratory Care Services for Ventilator-Dependent Individuals. The provision would become effective October 1, 1988. We anticipate small Medicaid savings and significant Medicare costs.

Section 721. Audit and Medical Claims Review. This section transfers \$105 million from the HI and SMI trust funds for payments to Medicare carriers and intermediaries to be used for the purpose of carrying out provider cost audits and review of medical necessity.

Legislation was originally considered and authorized under TEFRA, in which \$45 million mandatory audit and medical review monies was appropriated for fiscal years 1983, 1984, and 1985. The administration's fiscal year 1986 budget request for medical review and audit is \$181.8 million, which reflects the appropriation from the authorizing committee of \$45 million. Since the CBO baseline holds auditing/medical review activities at current law, no savings would be reflected from an extension of the appropriation.

Designating an additional \$60 million a year for audit/medical review activities would produce net savings of \$150 million in each fiscal year 1986, 1987, and 1988 based on a savings ratio of 5 to 1 for the addition of the first increment of \$30 million and a savings ratio of 2 to 1 for the second increment of \$30 million.

Section 722. Access to Skilled Nursing Facilities. This section provides that skilled nursing facilities (SNFs) with less than 1,500 Medicare days of care have the option of receiving a flat rate equal to 105 percent of the regional SNF mean per diem cost. The CBO estimate is based on simulations by the Urban Institute using 1980 nursing home data. The estimate assumes the increases in Medicare bed days in low volume SNFs are offset by decreases in bed days at larger volume SNFs and by decreases in home health visits.

Section 725. Physician Fee Freeze. Under current law, the customary and prevailing charges for all physician services are frozen for a 15-month period which expires on October 1, 1985. During this period, nonparticipating physicians are prohibited from charging their Medicare beneficiaries more than they charged during a base period from April through June 1984.

This bill would extend the freeze for an additional 12-month period, expiring on October 1, 1986, for nonparticipating physicians only. The current prohibition on increases in actual charges of nonparticipating physicians would also be extended for 12 months, beginning October 1, 1985. On October 1, 1986, any physician who signs a participation agreement effective for the year beginning October 1, 1986 would receive an increase in Medicare payments. For physicians not signing a participation agreement, increases in the prevailing would be lagged one year behind those of participating physicians. Furthermore, physicians who were formally participating under DEFRA and who switch to nonparticipating beginning October 1, 1985, would receive an increase in customaries equal to the increase in customaries expected by all other participating physicians under DEFRA who remain participating under the new freeze.

The CBO assumes that with the additional 12-month freeze, 47 percent of the reasonable charges for physicians would be participating dollars. This represents a shift of approximately 22 percent of nonparticipating reasonable charges to participating, and a shift of approximately 9 percent of participating reasonable charges to nonparticipating, based on the assumption that the 15-month freeze resulted in 35 percent of the reasonable charges being participating, and 65 percent; nonparticipating.

While participating physicians would be receiving allowed charges equivalent to amounts that would have been received by 1987 in the absence of any freeze, nonparticipating physicians who refused to participate in 1986 would not catch up to prefreeze reimbursements until 1990.

The Secretary would also be required to transfer \$15 million in Medicare Part B funds to the carriers for continued administration of the freeze and the participating physician program, and for the development of professional relations staffs dedicated exclusively to addressing the billing and other problems of participating physicians.

Section 726. Increasing Part B Premiums. Currently, premiums are set at 25 percent of SMI program costs for calendar years 1986 and 1987, and then based on COLA's for calendar years 1988, 1989, and 1990. Under this provision, premiums would be set at 25 percent of SMI program costs for calendar year 1988, increasing the estimated monthly premium amount from \$19.40 to \$20.80 for that year.

Section 728. Durable Medical Equipment (DME) Rental Freeze. A one percent cap would be placed on increases in the prevailing and customary charges for all rental durable medical equipment, prosthetic services, ambulance services, and all other nonphysician services currently paid on the basis of reasonable charges in fiscal year 1986. The prevailing charges for both rental and purchased DME, and all other medical supplies, would be increased thereafter to reflect changes in the Consumer Price Index.

Section 729. Assistants' Surgery Services for Routine Cataract Operations. This estimate was based on the Office of the Inspector General (OIG) Audit Report dated June 7, 1985. For the 29 states included in their review, there were about 576,000 cataract operations paid by Medicare for inpatient and outpatient operations during calendar year 1983, of which about 88,000 operations had additional payments for assistant surgeon charges at a cost of approximately \$33 million.

Section 730. Prosthetic Lens for Cataracts. The CBO based its estimate on a General Accounting Office (GAO) study that gathered data from 7 carriers in 1982. The estimate has two components: the savings from a uniform screen limiting the number of replacement lenses that Medicare will pay for and the establishment of a reasonable charge allowance for prosthetic lenses and for the related professional service. The estimated savings are based on cost data contained in the GAO study. CBO has extrapolated the data from the seven carriers examined in the GAO study to a national estimate.

Section 731. Preventative Services Demonstrations. The demonstration program will fund no fewer than five demonstrations. Based on proposals submitted to DHHS, the five projects are expected to average \$200,000 each for an annual total of \$1,000,000.

Section 732. Prospective Payment for Ambulatory Surgery. Under current law, facility charges for services rendered in hospital outpatient departments are reimbursed by Medicare on a reasonable cost basis. Facility charges for services rendered in ambulatory surgicenters are reimbursed by a fee schedule. Under this provision, outpatient departments would be reimbursed under the same fee schedule as ambulatory surgicenters. However, hospital outpatient departments would receive additional payments to reflect capital costs and graduate medical education. In addition, this provision would broaden the coverage of facility fees to include all services, supplies, and prosthetics related to the surgery except for physician services. Finally, this bill would impose cost-sharing on beneficiaries for surgicenter facility fees and physician charges.

Subtitle B--Medicaid and Maternal and Child Health

Section 744. Optional Hospice Benefits. This section would permit states to cover hospice services under state Medicaid programs. Costs for this provision are estimated to be insignificant because much of the care would substitute for hospital or nursing home care with similar or higher costs.

Section 745. Extension of Waiver Project. This provision would extend for three years a Section 1115 waiver to the state of Texas. On January 1, 1986, when the current waiver ends, there will be an estimated 3,185 grandfathered ICF-II recipients and 2,150 home care recipients no longer covered under Medicaid. If the waiver were not extended, it is possible that many of those ICF-II recipients would

receive more expensive ICF care resulting in higher federal expenditures. Some of the now relatively inexpensive home care recipients could also qualify for ICF care which would again lead to higher federal cost while those who did not qualify and would then no longer be receiving care would lead to federal savings. Due to the uncertainty surrounding the waiver recipients' eligibility for and access to ICF care in the absence of waiver renewal, it is difficult to estimate what costs would be for them. Based upon discussions with Texas officials, we understand that the extension of the waiver is unlikely to increase costs significantly.

Section 746. Third-Party Liability. State Medicaid programs would be required to increase collections from health benefit organizations which cover Medicaid recipients. In addition, this proposal would make Medicaid a payer of last resort to ERISA regulated plans. Currently, ERISA regulated plans can legally designate their plan as a secondary payer to Medicaid. The CBO estimate is based on data from the Current Population Survey and the National Medical Care Utilization and Expenditure Survey.

Section 747. Optional Targeted Case Management. States would be permitted to provide case management services to specific groups and/or specific areas without obtaining a home and community based services waiver. Based on data from states that offer case management under waivers, it is estimated that this proposal would result in savings of less than \$500,000 each year.

Section 748. Revaluation of Assets. This section modifies the revaluation of assets provisions of the Deficit Reduction Act of 1984. Under those provisions Medicaid payments to nursing homes may not be increased to reflect higher capital costs that result when nursing homes are sold. This section allows revaluation after a sale, but limits the increase to 50 percent of the nursing home cost index (Dodge Construction Index) or 50 percent of the CPI, whichever is lower.

Section 749. Beginning Date of Optional Coverage for Individuals in Medical Institutions. This proposal would allow certain Medicaid eligibles to be covered from the start of their institutionalized stay should their length of stay be 30 or more days. This would apply to individuals who are in the medical institutions but who have too much income to qualify for cash assistance. Current law provides that this special income standard be applied beginning with the first full month of institutionalization such that full coverage can only be applied to those whose date of entry is the first of the month.

Section 750. Optional Coverage of Children. Under the Deficit Reduction Act of 1984, states are required to provide Medicaid coverage for certain poor children under five years of age. The law required that coverage be phased in over a five-year period starting with the youngest children. This section allows states to provide coverage immediately to all these children. The CBO estimate assumes that only two states would exercise this option.

Section 751. Overpayment Recovery Rules. This provision would allow states 60 days to recover overpayments from providers before refunding the federal share of the overpayment. In addition, states would no longer be liable for the federal share of overpayments which cannot be collected from bankrupt providers. Allowing states 60 days to pay would have a one-time cost of \$7 million in 1986. Holding states harmless on the federal portion of overpayments to bankrupt providers is estimated to cost \$5 million a year.

Section 752. Home and Community-Based Services Demonstrations. Three-year demonstrations would be developed in four states to determine whether state-operated home and community-based care services are cost effective.

Section 759F. New Jersey Demonstration Project Relating to Training of AFDC Recipients as Home Health Aides. This proposal would continue for one additional year the demonstration project conducted by New Jersey with 50 percent federal matching. Based on 1984 expenditures for the project, the federal match in 1986 is estimated to be \$2 million.

Subtitle C--OASDI

Section 760. Demonstration Projects. This provision extends the deadlines for the reports that the Secretary of the Department of Health and Human Services (HHS) is required to submit to the Congress on the various experiments and demonstration projects authorized under the Social Security Disability Amendments of 1980. By specifying new reporting deadlines and by specifically extending waiver authority for the demonstrations, this section allows HHS to allocate funds to these projects over the next five fiscal years.

The costs of the demonstration projects are difficult to estimate as they would depend on the exact nature of the projects undertaken. The Social Security Administration (SSA) has indicated it anticipates the costs of the projects, when fully implemented, would total no more than \$5 million in any given year. The costs would be lower in 1986 because it would take time to design the specific projects and to award any contracts for these projects.

Section 768. Disability Offset Provision. This section modifies the Disability Insurance (DI) benefit offset for workers' compensation benefits and for public disability payments based on employment not covered under Social Security. The section has an impact on benefit payments because of the change in the treatment of benefits from plans primarily directed toward federal workers. The existing language would be changed from "benefits ...based on service all or part of which" to "benefits ...based on service all or substantially all of which". This has the effect of including under the offset provision more disability benefit payments received by federal workers.

Based on information provided by the Office of the Actuary of the Social Security Administration, the estimated outlay savings resulting from this section are negligible in fiscal year 1986, and reach \$2 million in 1989.

Section 769B. Deeming of Medicaid to Certain Disabled Widows and Widowers. Section 13 would deem Medicaid benefits to disabled widows and widowers who lost eligibility for SSI and Medicaid because of the 1983 increase in their Social Security benefits. Only such persons eligible for these benefits in December 1983 would be affected. The Social Security Administration estimates that up to 5,000 persons in 1983 were affected by the Social Security benefit change. Some would have died and others would already be receiving Medicaid under "medically needy" programs, leaving an estimated 3,000 persons who would now receive Medicaid. Because many would also receive Medicare, their average annual Medicaid costs are estimated to be only \$400. The cost of this provision would be about \$1 million annually for the 1986-1990 period.

**Subtitle D—AFDC, SSI, Foster Care, Adoption Assistance,
and Unemployment Compensation**

Section 770. Moratorium on Fiscal Sanctions. In AFDC and in Medicaid, a two-year moratorium would be placed on the collection of any fiscal sanctions from states. Because the fiscal sanction process would not be otherwise affected, CBO shows no loss or delay of sanctions, which CBO estimates in its baseline would not be collected before 1988. The cost of \$4 million in 1986 and 1987 would be for mandated studies.

Section 772. Payments to Indians. The treatment in means-tested programs of certain per capita payments to Indians would be altered. Currently, only single payments above \$2,000 per person are counted as income. The bill would require counting payments above \$2,000 per year per family. Little data exist on the extent and size of per capita payments, but based on conversations with analysts in the Bureau of Indian Affairs it appears that few Indians would be affected by this provision.

Sections 774-776. Foster Care and Adoption Assistance. The bill authorizes several expansions in Foster Care and Adoption Assistance. A new entitlement of \$1 million in 1986 would authorize payments to states for programs which would provide services, training, and/or counseling to foster care children age 16 or over to prepare them for independent living. Also, Medicaid coverage would be extended marginally to beneficiaries of adoption assistance, primarily to those who were placed for adoption but whose adoption was not yet finalized. An estimated 7,000 children would be affected.

The two-year extension of two expiring provisions in Foster Care--payments for children removed from the home under voluntary placement agreements and the ceiling and trigger provisions--would not affect federal costs as measured from CBO's baseline, which assumes extension of expiring provisions. There would be costs, however, measured from current law.

Section 776A. Recovery of Unemployment Compensation Overpayments. Under current law, no jurisdiction paying any form of jobless benefits to a worker who has received an unemployment compensation overpayment in another jurisdiction may reduce that worker's benefit by the amount of the overpayment. This provision would permit both the federal government--using trade adjustment assistance or other federal supplemental jobless aid--or states--using a new claim of an individual previously overpaid and recently moved to that state--to make such adjustments. Based upon Department of Labor fiscal year 1984 overpayment data, it is estimated that approximately 10 percent of both trade adjustment claimants and interstate unemployment claimants who file new claims will be affected by this provision. Assuming that the average future overpayment will be similar to the average overpayment in recent past years--about \$325--it is estimated that \$7 million would be saved in the 1986 to 1990 period.

Subtitle H—Pension Benefit Guaranty Corporation

Section 779A. Increase PBGC Premium. The bill would increase the Pension Benefit Guaranty Corporation's (PBGC) single-employer pension plan premium from \$2.60 to \$8.10 per participant for plan years beginning after December 31, 1985. Increasing the single-employer premium from \$2.60 to \$8.10 would result in an additional \$5.50 per participant in premium income. The increased premium collections would be credited to the public enterprise fund and a reduction in outlays would result.

Subtitle I—Revenue Provisions

Section 792. Tobacco Program Improvements. The bill would reduce price supports for tobacco, change the method of determining marketing quotas, facilitate the sales of existing tobacco stocks, and provide for purchaser assessments so that purchasers and producers share equally in maintaining the producer association "no net cost" funds for the 1985 and later crops of flue-cured and burley tobacco. Outlay savings, based on estimates provided by the Administration, result primarily from reduced Commodity Credit Corporation net lending outlays stemming from lower loan rates specified in the bill and increased domestic use and exports caused by lower market prices.

Section 793. Medicare Coverage For All State and Local Government Employees. This provision allows state and local government employees who would become newly covered under the Hospital Insurance (HI) payroll tax on October 1, 1986, to use their tenure in their current employment for the purposes of determining HI quarters of coverage. This is the same treatment accorded federal workers when the HI payroll tax was extended to them in 1983.

This treatment of newly covered state and local government employees is estimated to result in costs rising from negligible levels in fiscal 1987 to about \$10 million in 1990. Although little data are available on these currently noncovered workers, the evidence that does exist indicate that the outlay effects of this provision would be relatively small. About 30 percent of all state and local employees are currently noncovered, but many of these workers would already be expected to become eligible for HI. This would occur either as the result of being the spouse of a Social Security recipient, or as the result of the worker's own employment in Social Security covered employment before, during, or after any periods of noncovered work. Congressional Research Service estimates based on data from the March 1984 Current Population Survey (CPS) indicate that over three-quarters of non-covered state and local government employees eventually receive Medicare benefits. CBO's tabulations of the March 1985 CPS show about 360,000 fulltime state and local government employees--covered and noncovered--who were between the ages of 61 and 64. Adjusting these figures for the likely mortality and coverage patterns of these workers, as well as existing working-aged provisions, this provision could bring additional 8,000 to 9,000 persons into the Medicare program by 1990. The average annual cost of these new recipients is assumed to be similar to that of a relatively healthy Medicare beneficiary, or about \$890 in 1987 and rising to about \$1,140 in 1990.

6. ESTIMATED COST TO THE STATE AND LOCAL GOVERNMENTS:

Several subtitles of this bill would have an effect on state and local government budgets. These estimated effects are shown in the following table.

(by fiscal year, in millions of dollars)

	<u>1986</u>	<u>1987</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>
Subtitle A-Medicare	-5	-4	9	16	17
Subtitle B-Medicaid	-32	-113	-119	-125	-137
Subtitle C-OASDI	1	1	1	1	1
Subtitle D-AFDC	-8	-10	-7	-4	-4
Subtitle G-General Revenue Sharing	--	3,526	4,956	5,200	5,459
 Total Estimated State and Local Effects	 -44	 3,400	 4,840	 5,088	 5,336

Basis of Estimate:

Subtitle A, which reduces expenditures in the Medicare program, would change Medicaid outlays. Because states share in the financing of Medicaid--paying about 45 percent of outlays--their expenditures would change. Reductions in Medicare outlays reduce state and local copayments for those beneficiaries with dual Medicare/Medicaid coverage. The increased Medicare premiums are a cost to state Medicaid programs. Beginning in FY 1988, the additional premiums are larger than savings from federal Medicare cutbacks.

Subtitle B, which reduces Medicaid outlays, would lower state and local expenditures because the states finance somewhat less than one-half of outlays.

Subtitle C concerning OASDI contains a provision that would increase expenditures of state and local governments by \$1 million a year for the additional Medicaid coverage provided to certain disabled widows and widowers.

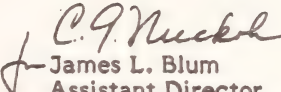
Subtitle D, concerning AFDC and several other programs, would reduce state and local expenditures slightly. The changed treatment of Indian income would lower expenditures by \$2 million a year while the extended Medicaid coverage under Adoption Assistance would raise expenditures by \$2 million to \$3 million a year. A provision affecting the Supplemental Security Income (SSI) program would reduce expenditures in Oklahoma by \$5 million to \$10 million a year, although it would have no effect on federal expenditures. The provision would modify the requirement under which states must "pass through" increases in federal SSI benefits.

Subtitle G, which eliminates General Revenue Sharing after October 1, 1986, would mean that local governments would lose projected annual payments of \$3.5 billion in fiscal year 1987 increasing to \$5.5 billion in 1990.

- 7. ESTIMATE COMPARISON: None.
- 8. PREVIOUS CBO ESTIMATE: None.
- 9. ESTIMATE PREPARED BY:

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- 10. ESTIMATE APPROVED BY:


James L. Blum
Assistant Director
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ADDITIONAL VIEWS OF SENATOR ORRIN G. HATCH

My colleagues and I on the Labor and Human Resources Committee have worked hard to come to agreement on these amendments to the Budget Reconciliation Act of 1985 relevant to our committee jurisdiction. These amendments reflect our commitment to deficit reduction by achieving approximately \$3 billion in savings over the next 3 fiscal years. However, in order to obtain approval from Senator Kennedy to move this bill, provisions were also included related to Federal mandates for private employers (requiring them to expand health benefit plans) and mandates that hospitals provide examinations or treatment for any individual who requests care in an emergency department. These provisions are part of S. 1615, the Health Care Improved Access Act of 1985 which was introduced on September 9, 1985.

The intent of this bill is honorable, that is to address concerns about inadequate health care for our citizens who do not have health insurance or who are "underinsured." I agree with Senator Kennedy that this is a problem, that as our health care system undergoes rapid changes, we must adapt to meet the needs of those least able to help themselves.

There is a percentage of our population who may not receive adequate health care services because they cannot afford them. They are without insurance because they are unemployed, have temporarily lost the protection of employee-based group insurance plans, or they are self-employed but unable to purchase insurance at affordable rates. Another category of underserved patients are those covered by affordable rates. Another category of underserved patients are those covered by medicaid, public health insurance for low-income individuals, but who are reportedly being refused hospital and medical care services because the reimbursement is considered too low to be "profitable." Such uninsured and underinsured individuals result in "uncompensated care" which is posing financial difficulties for hospitals and health care providers throughout the country.

During the past four years we have witnessed dramatic changes in our health care system. Traditional "fee-for-service" is being challenged by alternative delivery systems such as HMOs (Health Maintenance Organizations), IPAs (Independent Practice Association), and PPOs (Preferred Provider Organizations). The role of the hospital in our society is changing, no longer providing only acute in-patient medical care, but also providing several types of out-patient treatment, home care, and a broad range of social services. Our citizens have become much more savvy consumers—they have responded to incentives in group health insurance plans by becoming more careful and prudent purchasers of health services. All of

these changes have created a remarkably competitive environment with the inevitable confusion and frustration which accompanies change.

I am a strong advocate of competition in the health care market place. But there are some "symptoms" indicating our current system may be developing an "illness" which will need treatment. But I am confident this can be done without turning to the Federal Government for significant increases in public funding or regulation. With collaboration among the public and private sector, I am convinced we can solve problems related to uncompensated care.

There are reportedly 35 million citizens in our country who fall under the category of uninsured or underinsured. It has been estimated that the cost of providing care for this group was \$7.8 billion in 1983 and is rising. The reasons for the increases are complex, but among those frequently cited are the adoption of a prospective payment system for hospital care under medicare, the increasing frequency of negotiated discounts for private-paid employer health plans which limit the hospitals' ability to shift indigent care costs, and the rising costs in general.

Regardless of the causes, this problem must be addressed by society. Many are quick to say the problem lies with health providers—hospitals and physicians who are anxious to reap ever-increasing profits and who seem unconcerned with public health and well being. There have been disturbing reports about hospitals referring, and in some instances refusing to treat patients who present themselves for care, but who don't have health insurance. Others apparently require a substantial cash deposit from uninsured patients before admitting the individual for care. This has been referred to as taking a "wallet biopsy" before determining if the individual merits treatment. When this occurs to individuals in need of medical care it is unconscionable and completely contrary to the proud tradition of our health care professionals.

However, this problem is complex and the blame does not rest solely upon providers. Quality health care is expensive. As a society we are demanding more and better services. Thanks to Federal investments in basic science research, and a remarkably innovative and creative private enterprise system, we have a dazzling array of new medical technologies which promise improved health, relief of pain and disability, or at least postponing an inevitable appointment with death. None of us wants to stop progress, the advancement of science, or to discourage development of future cures and remedies. But I think it is imperative we pause and consider what services among the smorgasbord of available health care our society has a responsibility to guarantee to our citizens, regardless of their ability to pay.

Currently the Federal Government is shouldering a large portion or our Nation's health care costs, spending in excess of \$100 billion of public money annually to provide services to the poor and the elderly through medicare and medicaid. But if Congress is to control our Federal expenditures we must rein in expenditures under these programs. Please note that I did not say Congress must cut—

only that their costs must be cut. We must find ways of making certain that the enormous amounts of money currently being spent are directed to help those most in need of care. In the absence of Federal legislation mandating shifting of public moneys to individuals currently underinsured or uninsured, States have taken steps to solve this dilemma. States have developed two important models: (1) Providing health insurance coverage for persons temporarily uninsured; and (2) providing financial assistance to providers of uncompensated care. Examples of these approaches vary from State to State and are modeled after local and community needs. While it is important we give national attention to the problems of the uninsured and underinsured, I believe we must recognize the novel approaches created at the local and State level. We should encourage, and perhaps reward, States who develop innovative and effective solutions. At the same time, I believe we must proceed cautiously in addressing this problem, and not usurp or impede States in their efforts.

Therefore, I do not support the provisions of S. 1615 included in this bill. I believe they are premature, over-regulatory and unnecessarily punitive. Many health professionals and hospital organizations, employers and private insurance companies have expressed strong opposition to these provisions. Some of their views were included in the House report accompanying H.R. 3128 the Deficit Reduction Amendments, and I would like them included with this statement.

There is a more prudent and reasonable way of addressing the problem of uncompensated care. For example, the Catholic Hospital Association has proposed establishing the National Council on Access to Health Care to address a broad range of problems related to health care for the poor. Legislation to accomplish this was introduced by Senators Durenberger and Simon on September 10, 1985 (S. 1620). Although the bill calls for the council to make recommendation to Congress for legislative solutions on an annual basis for the next 3 years, it does not mandate Federal solutions to current concerns. This cautious approach is much more preferable than the provisions in S. 1615. I urge my colleagues to carefully review the provisions in this bill and consider alternative proposals when it is considered on the floor of the Senate.

SUBMISSION BY THE LAW FIRM OF KENNY NACHWALTER &
SEYMOUR

(The following letter was sent by the law firm of Kenny Nachwalter & Seymour to the Honorable Peter W. Rodino, Jr., on September 4, 1985.)

KENNY NACHWALTER & SEYMOUR,
Miami, FL, September 4, 1985.

Re: Deficit Reduction Amendments of 1985 (H.R. 3128)—
 Responsibilities of Medicare Hospitals in Emergency
 Cases.

Honorable PETER W. RODINO, Jr.,
Chairman, Committee on the Judiciary, House of Repre-
sentatives, 2137 Rayburn House Office Building, Wash-
ington, DC.

DEAR MR. CHAIRMAN: I am writing in regard to Section 124 of the Medicare Reconciliation Amendments of 1985 (Title I of the Deficit Reduction Amendments of 1985 [H.R. 3128]) which sets forth certain responsibilities of Medicare hospitals with respect to the provision of emergency medical services.

The Deficit Reduction Amendments were reported out of the Committee on Ways and Means on July 31, 1985, and Section 124 was referred to the Committee on the Judiciary for its consideration before September 11, 1985.

We represent a number of health care providers and a large fiscal intermediary in the State of Florida, and our interest in this subject flows from our involvement with many of the legal and economic issues relating to the provision of medical services to the indigent, and more particularly, with the difficult questions often raised by the subject of patient transfers. I am not writing on behalf of any specific client, but I thought that our perspective from an operating vantage point in which we often deal with the day-to-day challenges faced by both hospitals and physicians in the treatment of indigent patients might be of some interest to you and to the other members of the Judiciary Committee.

Section 124 requires all Medicare provider hospitals, as a condition of participation, to provide an "appropriate" medical screening examination to any person who requests to be examined, and it expressly prohibits "inappropriate" patient transfers to other medical facilities. A responsible physician who violates the Section's requirements may be imprisoned for as much as one year and fined \$100,000, or, if a transferred patient dies as a result, the physician may be sentenced to five years in prison and fined up to \$250,000. Civil penalties are also prescribed.

I am sympathetic to the concerns for patient safety which prompted the adoption of Section 124 by the Ways and Means Committee. I am concerned, however, that its enactment may signal a new and dramatic departure from the basic philosophical approach of the Medicare Act and that the practical operation of Section 124 may unavoidably result in some confusion and ambiguity and may lead to a degradation in the quality of American medical care and particularly in the availability of health care services to the poor.

During the twenty years since the enactment of Medicare, it has been the general philosophy of the federal government to refrain from interfering with medical decision-making by individual physicians and institutional providers or from limiting a beneficiary's freedom to choose among alternative sources of health care. These basic concerns have been incorporated into the Act itself at Sections 1801 and 1802 (42 U.S.C. §§ 1395 and 1395a), respectively.

To the best of my knowledge, Section 124, if enacted, will represent the first time that the federal government has attempted to regulate directly the manner in which medical services are provided. Section 124 seeks to prohibit inappropriate patient transfers and to require a medical screening examination for each patient who requests one. As laudable as these objectives are, however, their enforcement can only be obtained through the retrospective evaluation of intimate medical diagnostic and treatment decisions which have heretofore been left exclusively to the judgment of the physician and his patient. If section 124 becomes law, however, those decisions will be subject to the second opinion of federal prosecutors.

The enforcement of Section 124 will also be an extraordinarily complex task inasmuch as patients may be appropriately transferred to other facilities for a variety of legitimate reasons, not all of which are related to the patient's medical condition. A patient may be transferred because he or she belongs to a pre-paid health insurance plan or to a health maintenance organization which requires as condition of coverage that the patient be hospitalized in a particular facility. A patient may be transferred because his or her personal physician is on the staff of a different hospital or because the patient has established a prior relationship with a particular health care provider. Sometimes patients request to be transferred because they are eligible for the free medical care at a government hospital or at another public facility or because they wish to be treated at a location that is nearer to their residence, family and friends.

Individual decisions to transfer a patient often take place under the most difficult and time-sensitive circumstances. It may, for example, occasionally be the case that an emergency physician may redirect a patient to a different hospital on the basis of a brief examination when it is obvious that the transferring facility lacks the capability to provide for the patient's needs. The time required to examine the patient fully, complete a written determination that transfer is necessary and inform the receiving facility may literally mean the difference in some cases between life and death. At small or rural hospitals, a physician on call and away from the hospital may be required to authorize the transfer of a patient based upon the initial evaluation of an attending nurse. Section 124 may ultimately force small hospitals to choose between either clos-

ing their emergency departments or hiring additional, full-time medical personnel.

In addition, new modes of delivering emergency services have evolved during the past ten years which contemplate that patients will be routed to the nearest appropriate hospital, often on the basis of radio contact with rescue units or paramedics at the scene of an emergency. Regional trauma centers are specifically designed to direct patients among a number of different medical facilities so that patients may receive the best possible medical care as quickly as possible.

All of these developments and all of these possible transfer situations are entirely legitimate in the sense that the patients' ultimate welfare is thereby protected. Patient transfers take place for a wide variety of reasons, but Section 124 fails to take account of the fact that not all transfers are initiated for improper reasons. By sweeping all transfers into a single net, Section 124 may inadvertently penalize physicians who have actually served a patient's best interests by approving a transfer. It may encourage some emergency physicians to attempt procedures that they otherwise would not, and it may generally discourage transfers in all circumstances, even when motivated by a concern of the patient's best medical interests.

Section 124 is thus dangerously overbroad. Its enactment may contribute directly to a reduction in the quality of emergency medical services generally and indirectly to an increase in the overall costs of health care in the United States.

In addition to its overbreadth, important parts of Section 124 are extremely vague. It is not at all clear, for example, what is meant by "appropriate medical screening examination" as set forth in proposed Section 1867(a). If a patient is brought to a hospital suffering from a depressed skull fracture and the hospital has no neurological staff, is the examining physician nonetheless required to have the patient brought into the emergency department for an examination prior to the patient's transfer to an appropriate facility? Is a medical screening examination conducted by a nurse always "inappropriate"?

There is no guidance in Section 124 as to what satisfies the requirement of a written determination by a physician of the relative risks and benefits to the patient of a transfer to another medical facility as set forth in proposed Section 1867(c)(1)(A), and there is no indication of what purpose such a determination would serve. This requirement appears to constitute nothing more than an additional layer of regulatory paperwork, and it may result in a delay in treatment while the necessary forms are completed. More seriously, the language of Section 1867(c)(1)(A) would seem to prohibit any transfer of a patient until a physician can be summoned, a particular problem for hospitals which do not maintain full-service emergency departments.

I am particularly concerned by the requirement of proposed Section 1867(c)(2)(A)(ii) that the agreement of the receiving facility be obtained prior to transfer in all cases. We have encountered instances in South Florida where administrative personnel at receiving hospitals have arbitrarily refused to accept patient transfers that have already been agreed to between the responsible physicians. This provision would effectively mean that any hospital could unilaterally bar all patient transfers, regardless of medical necessity. In addition, there are occasions in which a patient's condition may be so critical that an immediate transfer is indicated and notice to the receiving facility can only be given once the patient is actually on the way. Proposed Section 1967(c)(2)(A)(ii) would prohibit such urgent transfers in all circumstances.

At the very least, to the extent that certification requirements and criminal penalty provisions are incorporated into the final act, I would suggest that such provisions should be made reciprocal. Any receiving hospital should be required to document the fact, that it does not have available space or qualified personnel for the treatment of the patient, and criminal penalties should be imposed for the violation of this requirement.

Section 124 provides for the civil enforcement of its requirements at proposed Section 1867(d)(3) by "any person or entity that is adversely affected . . ." I assume that this provision was inserted to create a cause of action on behalf of receiving medical facilities, a remedy which may seriously aggravate relations among hospitals in particular localities, but it is at least arguable that it will also inspire claims by ambulance companies and rescue services and many even be interpreted to include, for example, an individual who may be struck by an ambulance carrying a patient from one hospital to another.

The same paragraph stipulates that an action to recover damages for a violation of Section 1867 may be brought "in an appropriate court of general jurisdiction of the State in which the hospital is located or in the appropriate Federal district court . . ." If this language is interpreted to create concurrent federal jurisdiction, the result will be a geometric increase in the number of garden-variety medical malpractice cases handled by the federal courts with all of the consequent burdens of time and expense for the federal judiciary.

Proposed Section 1867(d)(3) also contemplates the imposition of equitable relief to "deter subsequent violations." The standards under which injunctions are to be issued to restrain future violations of the Section are not spelled out, however, and this particular remedy would appear to be available to prevent future transfers of other patients not before the court. Inasmuch as patient transfer decisions are typically unique to the medical condition and personal circumstances of each patient, it should prove to be very difficult for the courts to frame appropriate orders

and virtually impossible for them to monitor compliance. Because medical decision-making in any particular case is inherently a non-replicable type of activity, equitable sanctions would seem to be peculiarly inappropriate.

The primary test of physician criminal culpability spelled out in proposed Section 1867(d)(4)(A) is whether the physician's conduct represents "a gross deviation from the prevailing local standards of medical practice." To the best of my knowledge, this is a new formulation without any history of interpretation by the courts. In Florida, for example, the "accepted standard of care for a given health care provider [is] that level of care, skill, and treatment which is recognized by a reasonably prudent similar "health care provider as being acceptable under similar conditions and circumstances." Florida Statutes Section 768.45(1). How Section 124's definition will be applied in practice is unclear. It may turn out to be the case that juries will simply continue to award damages and will begin to convict physicians on the basis of their visceral sense of whether a patient has suffered any damage and how likely it is that civil penalties will ultimately be paid by malpractice insurers.

The availability of insurance coverage for violations of Section 124, however, is questionable. Most policies specifically exclude coverage for damages incurred as the result of criminal acts and insurance in such circumstances may otherwise be prohibited as a matter of state public policy.

Proposed Section 1867(d)(4)(A)(iii) sets forth the Section's criminal penalties. It provides that a responsible physician may be imprisoned for up to five years and fined as much as \$250,000 "if, as a direct result of the violation of this paragraph, the patient dies . . ." It is at least conceivable that the heightened penalties may be invoked in some instances because of substandard medical care rendered at a receiving facility which results in a patient's death. The net effect may be to make physicians at the transferring facility insurers against medical malpractice committed by a different medical facility.

I further believe that most of the definitions contained in proposed Section 1867(e) are inadequate and will lead to unfortunate results in practice. Both the definitions of "emergency medical condition," and "active labor" are very liberal. They would each appear to include situations in which a patient's true medical condition could not reasonably be detected by an examining physician prior to transfer. Indeed, the definition of "active labor" set forth at proposed Section 1867(e)(2)(C) would seem, to include women with high-risk pregnancies who might actually be several months away from their expected dates of delivery.

The terms "to stabilize" and "stabilized" set forth at proposed Section 1867(e)(4) stipulate that sufficient medical treatment must be rendered "to assure" that no material deterioration in the patient's condition will take place as the result of a transfer. This type of medical guarantee

is ordinarily impossible to make in actual practice; sometimes patients must be moved to other facilities for medical reasons despite the fact that the patient's condition might deteriorate in transit.

I am also troubled by the sweeping inclusion in proposed Section 1867(e)(5) of "any person employed by (or affiliated or associated, directly or indirectly with)" a hospital among those capable of triggering liability. I am sure what this definition contributes to the Section other than to expand the potential circumstances under which liability may be imposed.

Finally, Section 124, by its terms, is scheduled to take effect on October 1, 1985. This is an extraordinarily rapid effective date and will undoubtedly result in the Section's application to physicians and hospitals who are completely unaware of the Section's existence.

With respect to the enforcement provisions set forth at proposed Section 1867(d), I am generally very skeptical as to wisdom of the civil enforcement and criminal penalties provided for at proposed Section 1867(d)(3) and 1867(d)(4). It seems to me to be peculiarly inappropriate to use the Medicare Act as the vehicle for the introduction of new criminal sanctions against physicians, particularly when those sanctions can be invoked in behalf of patients who are not even eligible for Medicare benefits (as specified at proposed Section 1867(a) and 1867(b)).

More fundamentally, there already exist a variety of sanctions for deterring and punishing improper physician conduct, including the authorization of inappropriate patient transfers. I need not belabor the impact of medical malpractice liability on physician decision-making. Suffice it to say that virtually all states now recognize a duty on the part of both physicians and hospitals to render emergency medical assistance to those in need who present it at a hospital emergency department. Delaware was perhaps the first state to establish such a duty as a part of its common law. *Wilmington, General Hospital v. Manlove*, 174 A.2d 135 (Del. 1961). Many states, including Florida, have expressly enacted such requirements by statute. The Florida statute provides, in pertinent part, as follows:

No general hospital licensed under this part, and no specialty hospital with an emergency room, shall deny any person treatment for an emergency medical condition which will deteriorate from a failure to provide such treatment. (Florida Statutes Section 395.0143.)

By imposing affirmative obligations to render emergency treatment to all patients, regardless of financial status, most states have already enacted to means for attaining Section 124's objectives.

The Committee should also bear in mind that most states require the revocation of a medical license upon conviction of a felony related to the practice of medicine. In

Florida, such a requirement is incorporated at Florida Statutes Section 455.227(1)(c). Thus, the violation, purposeful or inadvertent, of Section 124 by a physician will almost always result in that physician's permanent removal from the profession.

I understand the concerns which motivated Section 124, and I believe that there are ways in which the section's objectives can be met. In particular, the review of patient transfer decisions as a matter of course should logically constitute one of the functions of the utilization and quality control peer review organizations established by Sections 1151 through 1163 of title 11 (42 U.S.C. §§ 1320c-1320c-12).

Otherwise, I fear the Section 124 is overboard in its application, vague in its requirements and unnecessarily severe in its sanctions. I would hope that the Congress would chose to consider this important subject in a deliberate fashion and not attempt to enact prophylactic legislation in haste and without an opportunity for public comment.

I am grateful for your tolerance for the length of my comments, and I hope that they may prove useful to you and the other members of the Committee. If I can be of any other service on this matter, please do not hesitate to let me know.

With best regards.

Very truly yours,

PAUL M. BUNGE.

LETTER SUBMITTED BY THE AMERICAN COLLEGE OF
EMERGENCY PHYSICIANS

(This following letter was sent by the American College of Emergency Physicians to the Honorable Peter W. Rodino, Jr. on August 30, 1985.)

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS,
Dallas, TX, August 30, 1985.

HON. PETER W. RODINO, Jr.,
Chairman, Committee on the Judiciary, U.S. House of Representatives, Rayburn House Office Building, Washington, DC.

DEAR MR. CHAIRMAN: The House Medicare/Medicaid Budget Reconciliation package, H.R. 3128, as approved by the House Ways and Means Committee, includes Section 124 pertaining to responsibilities of Medicare hospitals in emergency cases. That section addresses all patient transfers, not just transfers of Medicare patients. The American College of Emergency Physicians shares the Committee's concerns and does not condone inappropriate patient transfers, some of which have recently come to light in the television and newspaper media. However, turning a few selected cases into federal criminal offenses does raise a number of problems. Section 124 of H.R. 3128 has been re-

ferred to the House Judiciary Committee until September 11.

American College of Emergency Physicians is a national medical specialty society that was founded in 1968 to further the discipline of emergency medicine. Since that time, our membership has grown to more than 11,000 physicians who practice their specialty in emergency facilities across the country. Each year, approximately 77 million visits are made to emergency facilities by patients who depend on emergency care providers to evaluate and treat their illnesses and injuries and to stabilize all life—and limb—threatening conditions. Emergency physicians must be available 24 hours a day, seven days a week to provide such unscheduled, episodic care.

From working in hospital emergency departments, emergency physicians have first-hand experience in providing emergency care and in dealing with the many factors in a patient transfer decision. We also are currently providing much of the medical care that indigent patients are receiving. Every day, we see price-competitive incentives being built into the health care system that work against the poor and medically indigent patient. All third-party payers, including Medicaid, insurers, and employers, are implementing cost saving measures, and they are succeeding. We are concerned about the effects on care for the poor and the near poor.

Although we are in agreement with the objective of the legislation (i.e., to eliminate inappropriate patient transfers), we believe the statutory language is excessively punitive to emergency physicians without truly addressing the patient transfer problem. The language as approved by the Ways and Means Committee is so intimidating to emergency physicians that transfers which are in the best interest of patient care may be avoided or delayed. Because of the uncertain nature of the practice of emergency medicine and because of the retrospective standards of liability of this provision, emergency physicians may avoid transfers in order to protect themselves against criminal penalties and ultimate loss of their medical licenses because of the potential of felony convictions. Extreme caution could also result in prolonged detentions and unnecessary admissions. Neither is in the interest of patient care and both would increase health care costs.

Emergency physicians never know what types of cases will come into the emergency department. They must make rapid decisions regarding appropriate treatment, the need for hospitalization, and the type of consultation that may be needed. Time is often critical. The practice of emergency medicine is the challenge of making the best judgments under stressful conditions with limited information. This aspect also leaves the emergency physician most vulnerable to retrospective judgments as to what the physician "knows" (or has reason to "know") at the time multiple decisions are being made in the interest of emergency

care. The course of a patient's injury or illness is often unpredictable. Yet, the definition of "stablized" used in H.R. 3128 is not a medical (clinical) definition, but, rather, serves more as a warranty against "material deterioration of the condition." When is something "likely" to happen? In retrospect, if it did not happen, then it was not likely, but if something did happen in the course of time, then was it likely? Hindsight is always clearer than foresight.

Emergency physicians are central figures in the continuum of patient care. Emergency care begins in the prehospital setting, continues in the emergency facility, and concludes when the patient is discharged or when responsibility for the patient is transferred to another physician or facility. In most cases, emergency physicians do not have hospital admitting privileges and, therefore, are dependent upon hospitals and attending physicians to provide ongoing care to patients beyond the capacity of the emergency department. Only in very limited situations do emergency physicians provide inpatient services.

As central figures in the continuum of patient care, emergency physicians have become acutely aware of the patient transfer issue, as well as the more global problem of funding for indigent care. Insurers, employers, governments, physicians, and hospitals are all affected by this problem. The American College of Emergency Physicians has been and will continue to be committed to providing emergency care to indigent patients. ACEP has long held to the principle that all patients are entitled to emergency care, regardless of their ability to pay. We agree that all patients are entitled to have medical screening and stabilization. The College has established transfer guidelines which were recently expanded and updated, and we feel transfers are appropriate if they adhere to these guidelines. A copy of ACEP's patient transfer guidelines is attached. However, we as individual physicians cannot be held responsible for more than we can reasonably be expected to assure.

The conduct the proposed legislation is attempting to address is more appropriately governed by medical malpractice laws. Defensive medicine and medical malpractice are always recognized as major problems. Expanding the jurisdiction over malpractice claims into federal courts, as this bill does, will exacerbate the current medical malpractice crisis. Reprehensible as true malpractice may be, we feel it is unfair to single out emergency physicians for federal criminal penalties while allowing states to address all other forms of malpractice. We also feel strongly that the proposed approach is an intrusion into areas properly left to the states, namely standards of medical practice.

We note that Medicare started with paying medical bills for the elderly. The proposed provision brings us to the point of federal standards of medical care for the non-elderly backed by criminal penalties. This bill is also prece-

dent-setting in that it attempts to set standards for non-Medicare patients.

Under the proposed legislation, criminal penalties are being imposed in haste as part of a budget reconciliation process when the provisions is not a monetary item. The patient transfer provision was approved by the House Ways and Means Committee without hearings. If the intent of this legislation is to incorporate emergency care into Medicare participation criteria, the penalties should reflect already-existing sanctions within the Medicare Conditions of Participation for Hospitals. We believe hospital administrations, hospital governing boards, and hospital medical staffs should jointly develop plans that demonstrate how hospitals will handle patient transfer cases. Hospitals should be responsible for providing medical screening and stabilization, as defined medically, to all emergency patients who present for treatment. All hospitals should demonstrate they have established provisions for care by members of the medical staff for any patients who need admission, particularly when they are not eligible for transfer within the guidelines. All hospitals should also demonstrate they have established adequate disciplinary actions for violations of the transfer guidelines by members of the medical staff.

Because we feel the proposed legislation is extremely vague, and appears to be open to numerous interpretations, the American College of Emergency Physicians asks that time be taken to formulate a solution that will result in optimal patient care in these potential transfer situations. We are more than willing to work with you in developing alternative solutions and offer our assistance, and that of Virginia Pitcher, Director of the College's Washington Office, in addressing the patient transfer issue. Ms. Pitcher may be contacted at 2000 L Street, NW., Suite 200, Washington, DC 20036, telephone 202/861-0979.

Sincerely,

BRUCE D. JANIAK, MD, FACEP, *President.*

Enclosure.

THE EMERGENCY PHYSICIAN AND INDIGENT CARE

Emergency medicine is a distinct medical specialty, with approximately 15,000 physicians treating more than 77 million patients annually. It was recognized as the 23 medical specialty by the American Board of Medical Specialties in 1979, and the first board certification examination was administered in 1980.

Today, 66 residency training programs in emergency medicine have graduated more than 1,500 physicians, with an additional 1,300 in training. More than 3,000 physicians are board certified in emergency medicine. The American College of Emergency Physicians, founded in 1968, is the medical specialty society representing more than 11,000 emergency physicians.

Emergency physicians practice full-time in hospital emergency departments throughout the country. Their practice is unique because they treat a wide range of medical conditions, from the victims of automobile or industrial accidents to children who have swallowed household detergent. Emergency physicians also must recognize and treat cases of child abuse and rape, in addition to working with burn victims, hypothermia victims, and patients suffering potentially deadly allergic reactions.

The emergency department often serves as an access point for patients entering the overall health care system. Emergency physicians serve as a conduit and evaluate, stabilize, and treat all patients who present to the emergency department. Inpatient treatment is almost always the responsibility of other specialists. Because most emergency physicians do not have admitting privileges to the hospital, their role ends when the patient is discharged or responsibility for the patient is transferred to the admitting physician or another facility.

Because they serve as the access point to the health care system, particularly for those who have no personal physician, emergency physicians are acutely aware of the indigent population in America. Because the indigent population frequently has nowhere to turn for medical care except the emergency department, emergency physicians frequently treat indigent patients.

The reality of this situation was reflected in recent research conducted by Medical Economics. According to the March 5, 1985, issue of Medical Economics, emergency physicians' median net practice earnings are 8% less than the median for all medical specialists. The magazine states the "principal explanation is that a high proportion of emergency department patients either can't or won't pay, while medical ethics and the policy of most hospitals require that they be treated." Most states also have statutes or regulations requiring that patients who present to hospital emergency departments be seen without regard to their ability to pay.

The Medical Economics survey of physicians showed that the typical emergency physician in 1983 rendered more than \$25,000 in uncompensated care, compared to approximately \$17,000 in uncompensated care provided by all physicians surveyed. The Medical Economics data indicate emergency physicians as a specialty provided more than \$380 million in uncompensated care in 1983. Emergency physicians accept uncompensated care as part of their practice because their overriding concern is the patient's welfare.

Frequently, patients are transferred to other facilities following evaluation and stabilization. Transfers occur in all economic strata for any number of reasons. There are often important considerations that may justify a transfer in individual cases that are not strictly related to the availability or suitability of post-emergency medical care

in the transferring facility. Some of these considerations include:

An established medical relationship may exist between the patient and the receiving facility, including a history of prior admissions for other or related complaints;

The patient's personal physician may have attending privileges at the receiving facility and not at the transferring facility;

The patient's prior medical records may be on file at the receiving facility;

The patient may prefer to receive post-emergency medical care at a different hospital;

The patient's family, relatives and friends may be inconvenienced by admission of the patient to the transferring facility because of the distance between that facility and the patient's residence; and

The availability of free medical care at a public or government-financed medical facility may obviate or reduce the economic burdens that the patient might otherwise incur.

According to the American College of Emergency Physicians Patient Transfer Guidelines, the emergency physician's role in patient transfers is to stabilize the patient and establish medical responsibility for the patient with a physician at the receiving hospital before a transfer begins. Emergency physicians will make every effort to make the patient as comfortable as possible before the transfer begins. However, patients cannot always be pain-free before transfer because the pain may be a primary symptom needed to help the receiving physician diagnose and treat the patient.

Emergency physicians believe indigent health care is a crucial issue facing the country today. Transfer of patients is only one facet of this difficult problem. We, as a society, need to address all aspects of indigent health care, particularly the most significant element of the issue—the funding of indigent care. Emergency physicians will continue to staff emergency departments throughout the country and provide medical care to every patient who presents, regardless of their ability to pay.

POLICY STATEMENT ON TRANSFER OF PATIENTS ¹

From time to time, patients in an Emergency Department are transferred to other facilities. The transfer may be to another Emergency Department or directly to an in-patient facility. Clearly, not all physicians or medical facilities have the capabilities to care for every patient. At times, patients, or those responsible for them, request transfer to another facility for various reasons (which may

¹ Approved by the ACEP Board of Directors on August 13, 1985. These are guidelines and are not to be construed as standards of care.

or may not be medical); at times patients are transferred to receive the benefit of more appropriate facilities and/or services than are available in the given hospital or Emergency Department; and at times patients are transferred because of economic consideration, which may include the availability of free or reduced-cost medical care at a public or other facility or in accordance with the requirements of pre-existing contracts for patients of prepaid health plans that stipulate which facilities patients are to use.

Patients should not be transferred to another facility without first being stabilized. Stabilization includes adequate evaluation and initiation of treatment to assure the transfer of a patient will not, within reasonable medical probability, result in death, or loss or serious impairment of bodily parts or organs.

Stabilization of patients prior to transfer should include:

1. Establishing and assuring an adequate airway and adequate ventilation.

2. Initiating control of hemorrhage.

3. Stabilizing and splinting the spine or fractures when indicated.

4. Establishing and maintaining adequate access routes for fluid administration.

5. Initiating adequate fluid and/or blood replacement:

6. Determining that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion. The vital signs should remain within these parameters for a sufficient time prior to transfer to be reasonably certain they will not deteriorate while en route to the receiving hospital. However, there may be times when stabilization of a patient's vital signs is not possible because the hospital or Emergency Department does not have the appropriate personnel or equipment needed to correct the underlying process (e.g., thoracic surgeon on staff or cardiopulmonary bypass capability). In these cases, numbers 1-5 of the above should be performed and transfer carried out as quickly as possible.

At times, a patient or those responsible for the patient, may request a transfer that seems medically inappropriate. The physician is obliged to explain the medical risks involved, and an informed consent should be signed by the patient (or those responsible for the patient such as a parent or guardian) and the physician. In the event of such a transfer, the physician should still use every resource available in an attempt to stabilize the patient prior to transfer.

The following guidelines should be observed for transfer of patients:

1. The patient should be transferred to a facility appropriate to the medical needs of the patient. The facility should have adequate space and personnel available to care for the patient.

2. A physician or other responsible person at the receiving hospital must agree to accept the patient transfer prior to the transfer taking place. Acceptable "other responsible persons" should be medical personnel who are designated by the hospital and given the authority to accept the transfer of the patient. The patient transfer should not be refused by the receiving hospital when the transfer is indicated and the receiving hospital has the capability and/or responsibility to provide care to the patient.

3. Communication between responsible persons at the transferring and receiving hospitals for purposes of exchanging clinical information should occur prior to transfer. Ideally, this communication should be physician-to-physician.

4. Once a patient is accepted for transfer, an appropriate medical summary and other records (including lab results, and copies of EKGs and X-rays) should be sent with the patient.

5. A patient should be transferred via a vehicle that has appropriately trained personnel and life-support equipment. At times, it may be necessary for additional specialized personnel from the transferring or receiving hospital to accompany the patient.

At times, transfer of patients occurs routinely or is part of a regionalized plan for obtaining optimal care for patients at more appropriate and/or specialized facilities. In these situations there should be:

1. Written guidelines (e.g., types of cases appropriate for transfer) to govern the transfer of patients;
2. Pre-existing transfer agreements between the facilities, and;
3. Pre-transfer communication between appropriate responsible personnel.

STATEMENT SUBMITTED BY THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

(The following statement was sent by the American College of Emergency Physicians to the House Judiciary Committee on September 6, 1985.)

STATEMENT

The American College of Emergency Physicians (ACEP) is a national medical specialty society that was founded in 1968 to further the discipline of emergency medicine. ACEP's membership now includes more than 11,000 emergency physicians who practice their specialty in emergency facilities throughout the United States. Each year, more than 77 million visits are made to emergency facilities by patients who depend upon the specialized training and expertise of emergency care providers to stabilize and treat virtually every type of serious illness and injury. Emergency physicians constitute the front-line of American medicine and, in many instances, they are effectively the only

outpatient health care providers to a substantial portion of the nation's poorest citizens.

The United States Congress is currently considering the enactment of legislation which would regulate the provision of emergency medical services on a national basis. Section 124 of the Medicare Budget Reconciliation Amendments of 1985 (Title I of the Deficit Reduction Amendments of 1985 [H.R. 3128]) sets forth certain requirements and procedures to be followed by Medicare provider hospitals with respect to the provision of emergency medical treatment and imposes criminal penalties for the knowing violation of the section's requirements.

In general, ACEP believes that the objectives of Section 124 (proposed section 1867 of Title XVIII) in attempting to prevent the arbitrary transfer of patients who may suffer serious medical consequences as a direct result are laudable. There can be no question but the health and safety of each patient is of paramount importance and that no patient should be denied access to emergency medical treatment simply because he or she may lack the ability to pay. ACEP has consistently emphasized the responsibility of all physicians to adhere to the highest standards of medical care and ethics and to contribute to the health care needs of the medically indigent. Emergency physicians in particular have discharged their obligations in this regard with the utmost attention to the professional standards of their discipline and the public interest.

ACEP is very concerned, however, with the means proposed by Section 1867 for discouraging inappropriate transfers and most particularly with the criminal sanction provisions set forth at Section 1867(d)(4). In general, Section 1867 provides insufficient guidance to physicians and other responsible medical personnel as to their duties and obligations under the law, and its enactment may unintentionally result in the imposition of harsh criminal penalties on physicians who have fully conformed to the highest standards of medical ethics in the treatment of patients with emergency medical conditions. In addition, ACEP believes that the practical effect of the law's application may be actually to reduce the quality and availability of medical services to the poor and to raise health care costs generally, results which were not in the contemplation of Section 1867's sponsors.

As a consequence, ACEP believes that the enactment of Section 1867 as currently formulated would be highly inadvisable. ACEP's specific concerns with this legislation can be grouped into the following categories:

1. The subject of inappropriate patient transfers can best be dealt with as a part of the larger issue of indigent health care generally. Patient transfers are only one aspect of this overall problem which deserves the attention and consideration of the Congress.

2. A variety of effective mechanisms already exist for discouraging transfers which may endanger a patient's

health or well-being, and the civil and criminal sanctions embodied in Section 1867 are therefore largely redundant.

3. In practice, the implementation of Section 1867's requirements may lead to a host of interpretive difficulties which may result in its unfair application in individual instances and in a general degradation of medical practice and emergency health care.

4. Acceptable and effective alternative solutions exist which could reduce the incidence of inappropriate patient transfers while preserving the independence and professional integrity of the treating physician.

It is not ACEP's position that appropriate legislation cannot be formulated to deal with some of the problems associated with patient transfers. ACEP believes, however, that the subject is a complex one, that its nature and dimensions vary widely among localities and that a comprehensive solution cannot be arrived at in isolation without addressing the broader issues of indigent health care and its overall financial requirements.

1. Indigent Health Care.—No one understands the full dimensions of indigent health care needs in the United States or the degree to which those needs are being met. There are no comprehensive data on the subject and only fragmentary analysis of the impact of indigent medical care requirements in specific communities.

We do know, however, that recent changes in the health care industry have probably affected the delivery of medical services to the poor in an adverse fashion. The rapid introduction of competitive forces into the delivery of health services during the past few years has made it increasingly difficult for the private sector to absorb the costs of uncompensated care. Most notably, the implementation of the Prospective Payment System for Medicare reimbursement has exerted significant downward pressures on all hospital charges, eliminating the margin that used to be available for other purposes including the financing of indigent health care.

In addition, both consumers and third-party payors throughout the United States have become increasingly cost-conscious, and organized health care coalitions and new forms of group medical coverage such as preferred provider organizations and HMOs have reduced hospital utilization rates and cut average patient lengths of stay.

There is also a decreasing emphasis upon the provision of inpatient hospital services generally. Alternative health care delivery systems such as ambulatory surgical centers, freestanding emergency facilities and outpatient services of every sort have served to reduce hospital operating revenues and further limit the resources available for treatment of the poor.

The net effect of these developments has been to raise serious challenges to the continued financial viability of many hospitals. Some have already been forced to close; others can be expected to do so in the coming years. The

impact in terms of indigent health care has been to make it even more difficult for the private sector to absorb the costs of uncompensated medical services. Despite this fact, America's community hospitals have continued to contribute their fair share it has been estimated that the value or uncompensated hospital services rendered to the poor exceeds \$6 billion annually.

It is within the context of these sweeping changes in the health care industry that the issue of patient transfers must be considered. Realistically, the economic pressures generated by new competitive forces have increased the incentives to transfer patients to publicly-supported facilities where those patients may be eligible to receive free or reduced-cost medical care that is subsidized by tax revenues. Many private hospitals no longer have the option of admitting stabilized indigent patients to their facilities in every instance inasmuch as the fiscal stability of most hospitals has been undermined without providing an alternative source of funding for indigent health care costs.

Indeed, many public hospitals throughout the United States readily acknowledge the public nature of their responsibilities and accept indigent patients from private institutions as a matter of course. The overall prevalence and impact of indigent patient transfers from private institutions, however, is unknown. Much attention has recently been focused upon the anecdotal experiences of a few large public hospitals in major cities where it may well be the case that transfers are becoming a serious problem. There is reason to believe, however, that the nationwide incidence of inappropriate transfers is relatively slight and that many public hospitals are entirely able to accommodate patient transfers with no serious repercussions.

It is important to note, in this context, that an individual patient may be safely and appropriately transferred for a variety of reasons, not all of which are related to that patient's medical needs. It is not unusual for patients to be transported over long distances (occasionally across continents) with no perceptible risk to the patient involved. Patients may request to be transferred because they belong to pre-paid health plans which require their hospitalization in certain designated institutions. Patients may prefer to be hospitalized in a facility with which they have established a pre-existing relationship, because their personal physicians or medical records may be located at a different hospital, or because they simply wish to avoid the inconvenience and expense of an extended stay at a facility which is inconvenient or distant from their residence, family or friends.

In this regard, a patient's concern with the avoidance of debt likely to be incurred as a result of hospitalization at a private facility should not be discounted. While a patient's desire to seek admission to a public hospital may be motivated by economic concerns, ACEP believes that such a decision can be a legitimate one when free medical services

are available and that the patient's preferences in this regard should be respected. Indeed, no medical facility can purport to retain a patient contrary to that patient's expressed intention to refuse treatment and seek admission elsewhere. In such a circumstance, a medical facility has no choice but to assist the patient in arranging a safe transfer once it is clear that the patient's condition will not be adversely affected as a result.

The central point is that the subject of patient transfers is a subtle and complex issue whose full dimensions are not clearly understood. It is not a topic which is susceptible to quick and universal solution ACEP is concerned, however, that Section 1867, by mandating a nationwide regime of transfer standards enforced with criminal penalties, may inadvertently result in the exacerbation of the very situation it seeks to remedy.

In particular, ACEP fears that the enactment of Section 1867 may serve to discourage patient transfers under almost all circumstances. Faced with the prospect of substantial fines and possible imprisonment, many physicians may be understandably reluctant to authorize a transfer even when there may be a medical justification or when the patient has specifically requested to be transferred. The incentives to practice "defensive medicine" will become all the more compelling with the threat of criminal sanctions, and the consequent impact on health care costs generally may be unfortunate.

ACEP would consider such a development to be inconsistent with the standards of medical care and ethics and the goal of efficient health care delivery that it supports. This is particularly true inasmuch as ACEP believes that there are already existing mechanisms which strongly discourage inappropriate patient transfers in almost all cases.

2. Existing Disincentives to Inappropriate Patient Transfers.—ACEP is troubled by the implicit assumption of Section 1867 that severe criminal penalties are necessary to prevent physicians from arbitrarily transferring seriously ill and injured indigent patients to public facilities. There is no dispute that occasionally such transfers do take place, the ACEP suspects that their incidence may have been overstated in the popular media. By and large, the vast majority of physicians take their ethical responsibilities very seriously and render a significant amount of medical care without regard to a patient's ability to pay. Emergency physicians alone render an estimated \$300 million in uncompensated medical services each year.

In addition to each physician's personal ethical standards, the subject of patient transfers has been addressed by a number of professional medical organizations. Both the American Hospital Association and the Joint Commission on Accreditation of Hospitals have guidelines relating to this area. A hospital which allows inappropriate transfers risks the possible loss of its accreditation. The American College of Emergency Physicians has itself recently adopt-

ed revised guidelines concerning patient transfers from emergency departments, and a copy of those guidelines accompanies this statement.

Of more immediate impact to the individual physician is the ever-present threat of liability in tort. It is now well established that a physician who authorizes a transfer which endangers a patient's life or health may be sued as a result for medical malpractice. Typical of recent cases in this area is *Thompson v. Sun City Community Hospital*, 141 Ariz. 597; 688 P.2d 605 (1984), in which the Arizona Supreme Court held that an aggrieved patient could recover from a hospital for any damages sustained as the result of an improper transfer.

The specter of malpractice liability has profoundly affected the practice of medicine in recent years. Most physicians are at least cognizant of the potential legal risks associated with virtually all medical procedures and some have accordingly adopted extremely conservative diagnostic and treatment modalities. The result has unfortunately exerted some pressure on health care costs throughout the nation, and the recent tendency of juries to award large verdicts in malpractice cases has dramatically increased insurance premiums. Annual malpractice insurance premiums in obstetrics and some surgical specialties now approach \$100,000 in some states, and the availability of coverage for some disciplines is increasingly in doubt.

Faced with mounting insurance costs and the increasing prevalence of patient lawsuits, some physicians have reluctantly decided to abandon or restrict their practices. There can be no question but that physician accountability through the legal system has improved, but it has not been without cost. ACEP is concerned that the introduction of criminal penalties as an additional sanction for physician error may accelerate the departure of some physicians from the profession altogether and otherwise costs to the public at large.

From its perspective as the representative of the nation's emergency physicians, ACEP considers the existing disincentives to improper patient transfers to be sufficient. It is almost inconceivable that any emergency physician or hospital would knowingly run the substantial risks of civil liability that would result from a decision to transfer a patient contrary to that patient's best medical interests. ACEP acknowledges the fact that inappropriate transfers are, however, sometimes made. The existing legal system and the profession's standards of conduct, however, are capable of rectifying those mistakes when they occur and ensuring a just compensation for any patient who may suffer as a consequence.

3. *Practical Problems in Implementing Section 1867.*—In addition to ACEP's belief that Section 1867 provides for remedies that may not be necessary or that may be counterproductive in operation, ACEP is concerned by the section's lack of definitive guidance as to the precise conduct

prohibited. In general, the implicit premise underlying Section 1867 is that medical diagnosis is an exact science, susceptible in every case to precise, retrospective evaluation. Such, unfortunately, is not always the case. Emergency physicians, in particular, are often called upon to make rapid, difficult decisions concerning a patient's treatment which may include judgments as to the medical advisability of a transfer to another facility. Not every physician may agree in all instances as to the proper course of treatment, but the existence of professional disagreement does not necessarily indicate sub-standard care.

The difficulty with Section 1867 is that it is nondiscriminating in its application. Physicians may face the prospect of imprisonment and fines despite the fact that they have rendered the best possible care under the circumstances. The test of "gross deviation from the prevailing local standards of medical practice" as set forth in Section 1867 is inherently capable of a variety of interpretations.

Most disturbing is the fact that Section 1869 will, in fact, be interpreted and enforced not by medical peers but by U.S. Attorneys. ACEP believes that the interjection of non-physician review of the most intimate diagnostic decision-making is not only inadvisable as a matter of policy but contrary to the admonition of Section 1801 of the Medicare Act, 42 U.S.C. § 1395, that "[n]othing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided . . ."

Further, the practical operation of Section 1867 in many cases will be to place emergency physicians in the intractable position of having to provide extended care to emergency patients who might encounter some risk in transport. Most emergency physicians do not have admitting privileges in the hospitals where they practice. Should an emergency physician be unable to locate a staff doctor willing to admit and accept responsibility for the treatment of a patient, the emergency physician will then be faced with the impossible choice of either transferring the patient and risking eventual prosecution or retaining the patient in the emergency department, effectively on an in-patient basis.

Section 1867 will have a particularly harsh impact on the nation's small and rural medical facilities. Many hospitals of this sort operate emergency departments, but many of them are not fully staffed by physicians on a twenty-four hour basis and depend instead upon the services of skilled nurses who initially evaluate the patient's condition and on physicians who are on call outside the hospital. These hospitals sometimes provide the only first-aid and life-saving facilities in their communities, but they will be particularly vulnerable because of their limited resources to inadvertent violations of Section 1867's requirements. A physician who is not physically present in such

an emergency department but who is nonetheless on call and a "responsible physician" as defined in Section 1867(d)(4)(B) will be confronted with the prospect of criminal sanctions if he or she should authorize a patient transfer because it appears to be in the patient's best medical interests in light of the resources available at the transferring hospital at the time the patient is seen.

In addition, it is not clear from the language of Section 1867(a) what "an appropriate medical screening examination" is or who is required to provide it. The practice of emergency medicine has undergone considerable change in the past decade as new delivery systems such as regional trauma centers and areaswide telecommunications networks have evolved for the purpose of directing patients to the nearest appropriate medical facility as quickly as possible. It is sometimes the case that preliminary evaluations of a patient's condition must take place on an urgent basis and occasionally by means of radio contact with rescue units on the scene. The requirement of providing a complete medical screening examination prior to transfer may simply be impossible to fulfill in all circumstances and may often be contrary to the patient's best medical interests in obtaining prompt medical attention at the most appropriate facility.

ACEP is also concerned by the requirement of Section 1867(c)(2)(A)(ii) that the agreement of the receiving facility be obtained in all circumstances before a patient transfer is initiated. There have been instances in which non-physician administrative personnel at some medical facilities have intervened to block or countermand patient transfers already agreed upon between responsible physicians. It is ACEP's position that a decision as to medical advisability of any transfer is a medical determination to be made by the physicians on the scene and that administrative concerns should not interfere with that process. Just as the transferring hospital has a responsibility to conduct a patient transfer in a safe and appropriate manner, so too does the receiving hospital have a responsibility not to refuse a transfer arbitrarily when otherwise indicated.

ACEP believes that the civil enforcement provisions incorporated at Section 1867(d)(3) may potentially serve only to aggravate relations among hospitals in particular localities. The inclusion of "any entity" among those eligible to claim damages as a result of an inappropriate transfer may lead to the unfortunate spectacle of hospitals bringing suit against each other over patient transfer disagreements. The resolution of individual transfer situations can often best be handled on a more informal basis; the judicial system is particularly ill-equipped to mediate such disputes.

Further, ACEP is in doubt as to the potential implications of Section 1867(d)(3)'s stipulation that an action for damages may be brought "in an appropriate court of general jurisdiction of the state in which the hospital is locat-

ed or in the appropriate Federal district court." This provision may simply be an acknowledgement that certain actions will inevitably be filed in the federal courts as a part of their diversity of citizenship jurisdiction. It may, however, also be interpreted to create a new federal question basis for district court jurisdiction over cases arising out of Section 1867. If the latter, the result will be federal court adjudication of what are essentially medical malpractice cases now handled almost exclusively in state courts.

At the very least, ACEP doubts whether it is appropriate to provide for equitable sanctions in addition to the fines and other penalties already set forth in Section 1867. Each patient must necessarily be evaluated and treated on an individual basis, and it is not likely to be the case that separate patient transfers will share many of the same characteristics. Nonetheless, if injunctive relief is entered to restrain future patient transfers, it will be very difficult for a court to frame such an order and for an affected hospital or physician to know precisely what conduct has been restrained. The inevitable result may be continuing judicial supervision of ongoing medical decision-making, the kind of active judicial management of technical issues which most courts are reluctant to undertake.

The inherent ambiguity in many of Section 1867's provisions is illustrated by the definition of "to stabilize" as set forth in Section 1867(e)(4)(A). That definition stipulates that emergency medical treatment must be provided to a patient sufficient "to assure" that the patient's condition will not likely deteriorate as the result of a transfer. The practice of medicine is not, however, an exact science, and rigid guarantees and assurances as to the probable course of any illness or injury are simply not within the capacity of any physician to provide.

4. *Alternative Solutions.*—ACEP strongly believes that the subject of patient transfers and emergency medical care in general is sufficiently important to warrant careful and deliberate study by the Congress. The text of Section 1867 originated with the House Ways and Means Committee's deliberations on the Deficit Reduction Amendments of 1985, and no public hearings on Section 1867 have yet been held. The actual text of this legislation has been publicly available for only a few weeks. There is thus the distinct possibility that the bill may be enacted with virtually no opportunity for public comment and within the space of less than two months from start to finish.

Section 1867 is, however, a dramatic and controversial addition to federal law. ACEP believes that this legislation deserves careful and considered attention with an opportunity for the Congress to receive and evaluate the opinions of interested persons and organizations. It should not be enacted in haste as a part of the annual budget process.

Accordingly, ACEP would respectfully suggest that Section 1867 be severed from H.R. 3128 so that its merits and probable impact on American medicine can be separately

evaluated. The subject is far too important to be resolved by the enactment of criminal penalties as the panacea for a situation which is inadequately understood.

In this regard, ACEP would support legislation directing the Secretary of Health and Human Services to undertake a comprehensive study to determine the scope and dimensions of indigent health care needs in the United States. Such a study would constitute an invaluable contribution to our understanding of an important aspect of American health care. There is insufficient information on the degree to which the medical requirements of the poor are now being met, and it is time that a careful analysis be conducted of the impact on indigent health care of recent changes in the health care industry. One part of this study could appropriately be devoted to an examination of the incidence and effects of patient transfers.

With specific regard to emergency medical treatment, ACEP supports the concept that all hospitals should be required to develop plans governing the provision of emergency medical services and setting forth the procedures to be followed when transferring a patient to another facility. If necessary, such a requirement could be included as a condition of participation for Medicare reimbursement. The objective would be to ensure that every patient is provided with appropriate emergency medical treatment regardless of that patient's ability to pay.

Many states now enforce such standards either through legislation or by judicial interpretation, and the enforcement of such state legislation and the adjudication of claims on behalf of aggrieved patients should continue to be matters of administrative action and civil litigation. There is very little indication that these remedies have proven to be inadequate in the past. The use of federal criminal sanctions in a field such as emergency medicine which is characterized by subjective judgment and urgent decisionmaking is peculiarly inappropriate. The potential penalties are draconian in degree. Not only may some physicians be faced with lengthy prison terms and substantial fines for a mistake in judgment, but their future livelihood may effectively be destroyed. Most states automatically revoke a medical license upon conviction of a felony. The addition of criminal penalties to civil liability to loss of the ability to practice medicine amounts to the sort of cumulative sanctions that are both unnecessary and extraordinarily harsh.

If enacted as currently written, Section 1867 will take effect on October 1, 1985, only days after it is likely to be signed into law. There will be virtually no time for physicians across the country to know and understand their duties under the law and the possible penalties they may encounter. ACEP believes that the goals and objectives of Section 1867 are worthy of support, but that the means proposed may unfortunately prove to be disastrous in application.

The American College of Emergency Physicians firmly believes in the right of every patient to be treated with dignity and compassion. Adequate medical care should be available to every individual, regardless of economic status. As the national professional society of emergency physicians, ACEP will continue to support measures designed to strengthen and improve the provision of emergency medical services and to attain the goal of a society in which access to medical care is available to every person in need. In appropriate patient transfers are only one manifestation of the fact that America has not yet reached that goal. A resolution to this issue can be found, but it must be a solution which combines concern for the rights and dignity of the individual patient with an appreciation for the difficult and demanding challenges of the profession of emergency medicine.

The American College of Emergency Physicians stands ready to work with the Congress in formulating a reasonable and effective solution to this important issue.

POLICY STATEMENT ON TRANSFER OF PATIENTS ¹

From time to time, patients in an Emergency Department are transferred to other facilities. The transfer may be to another Emergency Department or directly to an inpatient facility. Clearly, not all physicians or medical facilities have the capabilities to care for every patient. At times, patients or those responsible for them, request transfer to another facility for various reasons (which may or may not be medical); at times patients are transferred to receive the benefits of more appropriate facilities and/or services than are available in the given hospital or Emergency Department; and at times patients are transferred because of economic considerations, which may include the availability of free or reduced-cost medical care at a public or other facility or in accordance with the requirements of pre-existing contracts for patients of prepaid health plans that stipulate which facilities patients are to use.

Patients should not be transferred to another facility without first being stabilized. Stabilization includes adequate evaluation and initiation of treatment to assure the transfer of a patient will not, within reasonable medical probability, result in death, or loss or serious impairment of bodily parts or organs.

Stabilization of patients prior to transfer should include:

1. Establishing and assuring an adequate airway and adequate ventilation.
2. Initiating control of hemorrhage.
3. Stabilizing and splinting the spine or fractures when indicated.

¹ Approved by the ACEP Board of Directors on August 13, 1985. These are guidelines and are not to be construed as standards of care.

4. Establishing and maintaining adequate access routes for fluid administration.

5. Initiating adequate fluid and/or blood replacement.

6. Determining that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion. The vital signs should remain within these parameters for a sufficient time prior to transfer to be reasonably certain they will not deteriorate while en route to the receiving hospital. However, there may be times when stabilization of a patient's vital signs is not possible because the hospital or Emergency Department does not have the appropriate personnel or equipment needed to correct the underlying process (e.g., thoracic surgeon on staff or cardiopulmonary bypass capability). In these cases, numbers 1-5 of the above should be performed and transfer carried out as quickly as possible.

At times, a patient or those responsible for the patient, may request a transfer that seems medically inappropriate. The physician is obliged to explain the medical risks involved, and an informed consent should be signed by the patient (or those responsible for the patient such as a parent or guardian) and the physician. In the event of such a transfer, the physician should still use every resource available in an attempt to stabilize the patient prior to transfer.

The following guidelines should be observed for transfer of patients:

1. The patient should be transferred to a facility appropriate to the medical needs of the patient. The facility should have adequate space and personnel available to care for the patient.

2. A physician or other responsible person at the receiving hospital must agree to accept the patient transfer prior to the transfer taking place. Acceptable "other responsible persons" should be medical personnel who are designated by the hospital and given the authority to accept the transfer of the patient. The patient transfer should not be refused by the receiving hospital when the transfer is indicated and the receiving hospital has the capability and/or responsibility to provide care to the patient.

3. Communication between responsible persons at the transferring and receiving hospitals for purposes of exchanging clinical information should occur prior to transfer. Ideally, this communication should be physician-to-physician.

4. Once a patient is accepted for transfer, an appropriate medical summary and other records (including lab results and copies of EKGs and X-rays) should be sent with the patient.

5. A patient should be transferred via a vehicle that has appropriately trained personnel and life-support equipment. At times, it may be necessary for additional special-

ized personnel from the transferring or receiving hospital to accompany the patient.

At times, transfer of patients occurs routinely or is part of a regionalized plan for obtaining optimal care for patients at more appropriate and/or specialized facilities. In these situations there should be:

1. Written guidelines (e.g., types of cases appropriate for transfer) to govern the transfer of patients;
2. Pre-existing transfer agreements between the facilities, and;
3. Pre-transfer communication between appropriate responsible personnel.

ORRIN G. HATCH.

CONSOLIDATED OMNIBUS BUDGET
RECONCILIATION ACT OF 1985

THE COMMITTEE OF CONFERENCE

SUBMITTED THE FOLLOWING

CONFERENCE REPORT

[To accompany H.R. 3128]



DECEMBER 19, 1985.—Ordered to be printed

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

DECEMBER 19, 1985.—Ordered to be printed

Mr. GRAY of Pennsylvania, from the committee on conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 3128]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the House to the amendment of the Senate to the text of the bill (H.R. 3128) to make changes in spending and revenue provisions for purposes of deficit reduction and program improvement, consistent with the budget process, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment insert the following:

SHORT TITLE

SECTION 1. This Act may be cited as the "Consolidated Omnibus Budget Reconciliation Act of 1985".

TABLE OF CONTENTS

Title I. Agriculture programs.

Title II. Armed services and defense-related programs.

Title III. Housing and community development programs.

Title IV. Transportation and related programs.

Title V. Corporation for Public Broadcasting and Federal Communications Commission.

Title VI. Maritime, coastal zone, and related programs.

Title VII. Energy and related programs.

Title VIII. Outer Continental Shelf and related programs.

Title IX. Medicare, Medicaid, and Maternal and Child Health programs.

Title X. Private health insurance coverage.

Title XI. Single-employer plan termination insurance system amendments.

Title XII. Income security and related programs.

Title XIII. Revenues, trade, and related programs.

Title XIV. Revenue sharing.

Title XV. Civil service, postal service, and governmental affairs generally.

Title XVI. Higher education programs.

Title XVII. Graduate Medical Education Council and technical amendments to the Public Health Service Act.

Title XVIII. Small business programs.

Title XIX. Veterans' programs.

Title XX. Miscellaneous provisions.

TITLE I—AGRICULTURE PROGRAMS

Subtitle A—Agricultural Program Savings

SEC. 1001. AGRICULTURAL PROGRAM SAVINGS.

The expenditures and outlays resulting from the provisions of title XI (relating to the export sales of dairy products) and title XIII (relating to emergency disaster loans and loan authorizations under the Agricultural Credit Insurance Fund) of the Food Security Act of 1985 (H.R. 2100, 99th Congress) shall be counted for purposes of determining savings under the Consolidated Omnibus Budget Reconciliation Act of 1985 as having been enacted under this Act.

Subtitle B—Tobacco Program Improvements

SEC. 1101. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress finds that—

(1) the maintenance of a viable tobacco price support and production adjustment program is in the interests of tobacco producers, purchasers of tobacco, persons employed directly or indirectly by the tobacco industry, and the localities and States whose economies and tax bases are dependent on the tobacco industry;

(2) the present tobacco price support program is in jeopardy and in need of reform;

(3) under present law, the levels of price support for tobacco have resulted in market prices for tobacco that are not competitive on the world market;

(4) as a consequence, extremely large quantities of domestic tobacco have been put under loan and placed in the inventories of the producer-owned cooperative marketing associations that administer the tobacco price support program;

(5) the increased inventories have led to a significant increase in the assessments producers are required to pay to maintain the tobacco price support program on a "no net cost" basis;

(6) such increasingly large assessments are creating a severe hardship on producers;

(7) the existence of such large inventories poses a threat to the orderly marketing of future crops of tobacco;

(8) inventories of producer associations must be significantly reduced or the tobacco price support program will collapse;

(9) the Commodity Credit Corporation is threatened with substantial losses on disposition of these inventories should the tobacco price support program collapse;

(10) it is imperative that such excess inventories of tobacco be disposed of, under the supervision of the Secretary of Agriculture, in a manner that—

Senate amendment

The Secretary of Defense and the Secretary of Health and Human Services would be required to study jointly the possible effects of the adoption for the CHAMPUS program of a prospective payment system for inpatient hospital services like the one use for medicare. The study would address: (1) the advisability and feasibility of requiring by law that a hospital participate in the CHAMPUS program as a condition of participating in medicare; and (2) the changes that might be expected, if such a system were adopted, in the CHAMPUS patient workload and the CHAMPUS aggregate payment levels to various segments of the provider community (e.g. hospitals and nursing homes).

The report with recommendations would be submitted to the Committees on Armed Service and Finance in the Senate and the Committees on Armed Services and Ways and Means in the House of Representatives no later than December 1, 1985.

Conference agreement

House recesses with an amendment. The date for submission of the report would be extended until June 30, 1986. The conferees expect the Secretaries to issue the report in a timely fashion.

2. Requirement of Medicare providers of Hospital services to participate in CHAMPUS and/or CHAMPVA programs. (section 205 of the Senate amendment)

Present law

Current law contains no requirement that medicare-participating hospitals accept beneficiaries of CHAMPUS or CHAMPVA. Current law imposes no requirement on such hospitals regarding acceptance of payment amounts under these programs as payment in full.

Section 931 of the Department of Defense Authorization Act for fiscal year 1984 included a provision authorizing CHAMPUS and CHAMPVA to utilize medicare reimbursement procedures in paying for care under these programs.

House bill

No provision.

Senate amendment

The bill would require a medicare-participating hospital to accept and also participate in the CHAMPUS and CHAMPVA programs and to accept payment made under both programs as payment in full.

The bill would be effective, generally on October 1, 1985.

Conference agreement

House recesses with an amendment. Admissions practices, payment methodologies and amounts would be prescribed in regulations jointly issued by the Secretary of Health and Human Services and the Secretaries of Defense and Transportation. It is the intent of the managers that the Secretary of Defense will identify hospi-

tals which fail to meet this additional condition and convey that information to the Secretary of HHS for appropriate action.

The Secretary of HHS would be required to report to Congress periodically on the number of hospitals that have terminated or failed to renew an agreement as a result of this additional requirement.

3. Requirement of Medicare providers to accept Veterans' Administration beneficiaries (section

Present law

Current law does not require medicare-participating hospitals to accept Veteran Administration beneficiaries.

Further, the Administrator of the VA contracts individually with facilities to provide services to eligible veterans. The Office of Management and Budget is requiring the VA to cap reimbursement rates under these contracts at levels similar to rates established for medicare beneficiaries.

House bill

The bill would require medicare participating hospitals to accept Veterans' Administration (VA) beneficiaries on a basis similar to medicare and requires them to accept payment amounts determined under VA regulations as payment in full. The Secretary of HHS would be authorized to take corrective action or to terminate a provider's agreement for failure to comply.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House bill.

TITLE III—HOUSING AND RELATED PROGRAMS

Section 3002 prohibits The Federal Financing Bank from purchasing notes or other obligations guaranteed under Section 108 of the Community Development Block Grant Program after June 30, 1986, and requires the Secretary of HUD by July 1, 1986, to take the actions necessary to provide for the financing by the private sector of loans guaranteed under Section 108.

Section 3003 authorizes \$1.279 billion in fiscal year 1986 for public housing operating subsidies.

Section 3004—Provides that loans made for public and Indian housing, as well as modernization assistance, will be forgiven at the end of each fiscal year. It also gives direction for the use of the budget authority in the HUD Independent Appropriations Act of 1986, P.L. 99-160, which provides funds for new public housing development and modernization on the basis of long-term financing. As the legislative language the conferees adopted forgives the future public housing indebtedness and as this is tantamount to capital grant financing, the conferees intend that any budget authority that becomes available due to the change in financing will be rescinded. If this approach is used the conferees intend that any budget authority not needed to fund the 7000 additional public and

The amendment includes new language which provides that the scope of judicial review of the Secretary's decision shall be that applied to final federal agency actions by the Administrative Procedure Act, 5 U.S.C. 706(2)(A)—“arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law”.

The amendment repeals subsection (d) of existing law.

SUBTITLE C—USE OF AMERICAN-BUILT RIGS FOR OCS DRILLING

Section 8201—Use of American-built rigs for OCS drilling

The Senate receded to the House on Title VI, Subtitle H of the Merchant Marine Committee version—Use of American-built Rigs for OCS Drilling.

TITLE IX—MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

SUBTITLE A. MEDICARE

1. Rate of increase in payments for inpatient hospital services (sec. 101)

Present law

Current law generally provides that the medicare prospective payment rates should be updated annually by the Secretary of Health and Human Services. The law states that the update for FY 1986 should take into account amounts necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality, but may not exceed the rate of increase in the hospital market basket index (the increase in hospital input prices) plus one quarter of a percentage point. The Secretary of HHS promulgated final regulations freezing hospital medicare payments for FY 1986 at the FY 1985 levels. Public Law 99-107, the Emergency Extension Act of 1985, amended current law to provide that the payment rates in effect on September 30, 1985 should remain in effect for a further 45-day period, through November 14, 1985. Public Law 99-155 extended this requirement through December 14, 1985, and Public Law 99-181 extended the requirement through December 18, 1985.

House bill

The bill would require that the Secretary provide a 1 percent increase in the PPS payment rates for FY 1986. A similar rate of increase would be provided for PPS-exempt hospitals, which remain under a cost reimbursement system. For PPS hospitals, the provision would be effective for discharges occurring during FY 1986 for the Federal portion of the prospective payment rates. For the hospital-specific portion of the payment rates in PPS hospitals, and for PPS-exempt hospitals, the provision would take effect for the hospital's cost reporting period that begins during FY 1986.

Senate amendment

The provision would require the Secretary of Health and Human Services to provide a 0.5 percent increase in the PPS rates for fiscal year 1986 and an increase no greater than the increase in the hospital market basket index in fiscal years 1987 and 1988. Addi-

tionally, the payment limits for PPS-exempt hospitals and units would be increased by 0.5 percent for fiscal year 1986 and by an increase of no more than the hospital market basket in fiscal years 1987 and 1988.

The provision would be effective for hospital cost reporting periods beginning on or after October 1, 1985, for the hospital-specific portion of the PPS rates, and for discharges occurring on or after October 1, 1985, for the Federal portion of the PPS rates. For PPS-exempt hospitals, the provision would take effect for hospital cost reporting periods beginning on or after October 1, 1985.

Conference agreement

The conference agreement includes the House bill with the following modifications. The conference agreement extends the current freeze on the PPS payment rates and on the cost limits for PPS-exempt hospitals through February 28, 1986.

For PPS hospitals, the Secretary will be required to provide an increase of 1 percent in the PPS payment rates for the remainder of fiscal year 1986 and an increase no greater than the increase in the hospital market basket index in fiscal years 1987 and 1988. For fiscal year 1986, the increase in the Federal portion of the rates will take effect for discharges occurring on or after March 1, 1986, and the increase in the hospital specific portion of the rates will take effect with the beginning of the sixth month of the hospital's first cost reporting period beginning on or after October 1, 1985 (e.g., June 1, 1986, for a hospital with a cost reporting period beginning on January 1, 1986; and December 1, 1986 for a hospital with a reporting period beginning on July 1, 1986).

For PPS/exempt hospitals, the Secretary will be required to increase the applicable cost limits for fiscal year 1986 by seven-twelfths of 1 percent (0.5833 percent) effective for hospital cost reporting periods beginning on or after October 1, 1985 but before October 1, 1986. For fiscal years 1987 and 1988, the Secretary will be required to provide an increase in the cost limits that is no greater than the increase in the hospital market basket index. Further, in computing the cost limits for fiscal years 1987 and 1988, the increase for fiscal year 1986 shall be deemed to be 1 percent rather than 0.5833 percent.

2. One-year extension of transition to national DRG rates (sec. 102)

Present law

The Social Security Amendments of 1983 (P.L. 98-21) provided for a new prospective payment system for hospital inpatient services provided to medicare beneficiaries.

Current law provides for a three-year transition from payments based on hospital specific costs to payments based on national DRG (diagnosis related group) rates. During this period, a declining portion of the total prospective payment will be based on a hospital's historical reasonable costs and an increasing portion will be based on a combination of regional and national DRG rates. In the fourth year of the program and thereafter, medicare payments will be determined under a totally national DRG payment methodology. The blend of the historical cost (hospital specific) portion of the pay-

ment rate with the Federal portion of the DRG payment rate is changed with the beginning of the hospital's cost reporting period.

The Federal DRG component is comprised, for the first three years, of a combination of national and regional rates. This phase-in takes account of current differences in hospital costs across regions; different payment levels are provided for nine census regions of the United States. Changes in the blend and the amounts of the national/regional components of the Federal DRG payment rates are made on the Federal fiscal year basis. The prospective payment rate transition started with each hospital's first cost reporting period that began on or after October 1, 1983. The current transition schedule is shown below.

For hospital cost reporting periods beginning on or after:

Fiscal year ¹	Hospital specific portion (percent)	Federal DRG portion (percent)
1984	75	25 (100 percent regional)
1985	50	50 (25 national, 75 regional)
1986	25	75 (50 national, 50 regional)
1987	0	100 (100 national)

¹ The hospital specific portion (HSP) amount and the proportional shares of the HSP and the Federal DRG amount change with the beginning of the hospital's cost reporting period. The Federal (national and regional) rates and their proportional shares change with the beginning of the Federal fiscal year.

P.L. 99-107, the Emergency Extension Act of 1985, amended current law to provide that hospital payment rates that were in effect on September 30, 1985 should remain in effect for a further 45-day period, through November 14, 1985. This change also suspends the transition at the blend of 50 percent hospital specific/50 percent Federal for the 45-day period. Public Laws 99-155 and 99-181 extended this requirement through December 18, 1985.

House bill

The bill would extend the transition period for one additional year. The 50 percent hospital specific cost/50 percent Federal DRG payment rate blend would be maintained for FY 1986. Since changes in the regional/national composition are made on a Federal fiscal year basis, the transition schedule would be revised as follows. For hospital cost reporting periods beginning on or after:

Fiscal year ¹	Hospital specific portion (percent)	Federal DRG portion (percent)
1984	75	25 (100 percent regional)
1985	50	50 (25 national 75 regional)
1986	50	50 (25 national, 75 regional)
1987	25	75 (50 national 50 regional)
1988	0	100 (100 national)

This provision would have two effects. First, it would continue to base 50 percent of the payment on the hospital's own historical cost base for one more year. Second, it would continue to base 75 percent of the Federal portion of the payment rate on regional costs for one more year. For the blend of the regional and national portions of the Federal component of the payment rate, the provision would be effective for discharges occurring on or after October 1, 1985. The blend of the hospital specific and Federal portions would be effective for discharges occurring during hospital cost reporting periods beginning on or after October 1, 1985.

¹ The hospital specific portion (HSP) amount and the proportional shares of the HSP and the Federal DRG amount change with the beginning of the hospital's cost reporting period. The Federal (national and regional) rates and their proportional shares change with the beginning of the Federal fiscal year.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with the following modifications. Beginning with the sixth month of the hospital's cost reporting period beginning during fiscal year 1986, the hospital specific/Federal blend will be 45 percent hospital specific and 55 percent Federal. For hospital cost reporting periods beginning during fiscal year 1987 the hospital specific/Federal blend will be 25 percent hospital specific and 75 percent Federal. Effective for discharges occurring on or after March 1, 1986 and before October 1, 1986 the blend of the Federal rate components will be 75 percent regional and 25 percent national. For discharges occurring during fiscal year 1987, the blend of Federal rate components will be 50 percent regional and 50 percent national.

The conferees believe that this modification in the transition will give all hospitals more time to adjust to the prospective payment system. In addition, it would provide hospitals in higher cost regions of the country an opportunity to make the necessary changes to reduce their costs. This modification in the transition to national rates does not reflect a lack of support for the prospective payment system. The conferees do not believe that any further delay in the transition to national rates is warranted. The conferees believe that significant progress must be made in developing refinements to the DRG system to more accurately reflect the actual costs incurred in providing care. For example, the conferees, in this legislation, have requested a report on refining the hospital wage index to reflect the higher costs incurred in core city areas relative to suburban areas. In addition, the conferees anticipate that significant progress will be made toward implementing a severity of illness index.

It has come to the conferees' attention that burn center hospitals may be among these hospitals that will require special treatment because of the extensive treatment needs of their patients. For these hospitals, up to one-half of the burn patients may be outliers—far in excess of the percentage contemplated by the PPS. The Secretary is requested to review the adequacy of the payments being made to burn center hospitals under PPS and any problems of access that the present payment method may be creating for medicare patients.

3. Application of revised hospital wage index (sec. 103)

Present Law

As an integral part of the medicare prospective payment system (PPS) for hospitals, the Federal portion of the prospective payment rates is adjusted to take into account differences in wages from area to area. This is accomplished by means of an area wage index applied to all PPS hospitals in urban and rural areas. The current hospital wage index is constructed from a national data base of hospital wage records maintained by the Bureau of Labor Statistics (BLS). There are a number of technical flaws in this index, princi-

pally that it fails to recognize differences at the local level regarding the number of part-time hospital workers.

In response to requirements in the Deficit Reduction Act of 1984, P.L. 98-369, the Health Care Financing Administration developed a new "gross hospital wage index," based on a more refined survey of hospital wage costs. This index is derived from total gross hospital wages including salaries of interns and residents, personnel employed in areas other than the inpatient area, hospital-based physicians and all other salaries paid to hospital employees. P.L. 98-369 required that any new wage index be implemented retroactive to October 1, 1983. According to the PPS final regulations published September 3, 1985, HCFA planned to implement the new wage index October 1, 1985, retroactive to October 1, 1983.

P.L. 99-107, the Emergency Extension Act of 1985, amended current law to provide that medicare hospital payments would be determined on the same basis as they were on September 30, 1985, effective through November 14, 1985. Public Law 99-155 extended this requirement through December 14, 1985, and Public Law 99-181 extended it through December 18, 1985. This means that there can be no change in the wage index until after this date.

a. New gross wage index

House bill

The Secretary would be required to implement the new "gross wage index" published in the proposed PPS regulations on June 10, 1985. The provision of current law requiring retroactive application of the new wage index would be repealed. The house bill does not preclude the Secretary from making adjustments to reflect computation errors that may have been made in calculating the specific index amounts. The provision would be effective for discharges occurring during fiscal year 1986.

The House bill requires that the gross wage index be used for FY 1986. Further, the House bill requires the Secretary to make refinements, as necessary, in the area wage index for FY 1987 and beyond.

Senate amendment

Similar provision, except references final PPS regulations published September 3, 1985. The provision would be effective for discharges that occur during FY 1986, with Secretarial authority to make periodic adjustments in the appropriate wage index for discharges occurring after September 30, 1986.

Conference agreement

The conference agreement follows the Senate amendment with a modification that the provision would be effective for discharges occurring on or after March 1, 1986.

b. Wage index study

House bill

The Secretary would be required to study, in consultation with the Prospective Payment Assessment Commission, and make a rec-

ommendation to the Congress by May 1, 1986, on refining the area wage adjustment to reflect the higher wage costs incurred by hospitals located in core city areas relative to those in suburban areas of the same metropolitan area.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification of the reporting date to March 1, 1987.

4. Change in formula for indirect teaching adjustment (sec. 104)

Present law

The medicare program provides reimbursement for both the direct and indirect costs of medical education incurred by teaching hospitals. The direct costs of approved medical education programs (such as salaries for residents and teachers and classroom costs) are excluded from the prospective payment system, and are reimbursed on a reasonable cost basis. The indirect costs are increased patient care costs associated with teaching programs due to such factors as increased diagnostic testing, increased numbers of procedures prescribed, higher staffing ratios, and a more severely ill patient population.

A proxy measure, defined as the hospital's ratio of the number of interns and residents divided by the number of beds (IRB), has been used to adjust medicare prospective payments for indirect medical education costs. An adjustment factor for indirect medical education costs was estimated statistically based on the increase in hospitals' costs as their ratio of interns and residents to the number of beds (IRB) increases. This factor was first used as an adjustment to the medicare limits on hospital payments under the former cost-based reimbursement system.

When Congress enacted the prospective payment system, it established the indirect teaching adjustment factor at double the factor which was in effect as of January 1, 1983. After recomputing this factor, the Health Care Financing Administration estimated, on a linear basis, that a 0.1 increase in the IRB ratio would result in a 5.79 percent increase in a hospital's cost per discharge; doubled, the indirect teaching factor was established at 11.59 percent. This adjustment is made to the Federal DRG portion of the PPS rate only. The adjustment was doubled because of concerns that the DRG system would adversely affect teaching hospitals. These concerns stemmed from doubts about the ability of the DRG case classification system to fully account for factors such as severity of illness, urban location, bed size, and increased medicare costs associated with hospitals that serve large numbers of low-income patients. The doubling of the indirect teaching adjustment from 5.79 percent to 11.59 percent was done on a budget-neutral basis, which means that the DRG payments were adjusted downwards overall to account for the doubling of the indirect teaching adjustment.

a. Adjustment reduction

House bill

The House bill would reduce the indirect teaching adjustment to 8.1 percent (for FY's 1986 and 1987) and 8.7 percent (for FY's 1988 and beyond) for each 0.1 increase in the IRB ratio, on a variable or curvilinear basis. (An adjustment made on a variable basis reflects the non-linear cost relationship; that is, each increase in residents-to-bed ratio does not result in a proportional increase in costs).

The reduction from 8.7 percent to 8.1 percent in FY 1986 and FY 1987 recognizes that a portion of the indirect teaching adjustment compensates hospitals serving a disproportionate share of low-income patients. When the disproportionate share payment provisions expire at the end of FY 1987, the indirect teaching adjustment would revert to 8.7 percent.

The savings from the reduction in the indirect teaching adjustment from 11.59 percent on a linear basis to 8.7 percent on a curvilinear basis would be total systems savings. The savings from the further reduction from 8.7 percent to 8.1 percent would be used to offset the additional costs of the disproportionate share provision.

Senate amendment

The Senate amendment would reduce the indirect teaching adjustment from 11.59 percent to 7.7 percent on a variable, or curvilinear basis, for fiscal years 1986 and 1987, and 8.7 percent for fiscal years 1988 and beyond.

Conference agreement

The conference agreement includes the House bill with an amendment to clarify effective dates (see item (g)).

b. Intern outpatient counting

House bill

The House bill would provide that interns and residents assigned to outpatient departments of a hospital would be counted for purposes of determining the indirect teaching adjustment.

Senate amendment

There is a similar provision in section 704 of the Senate amendment.

Conference agreement

The conference agreement includes the Senate amendment.

c. Restandardizing the DRG rates

House bill

The House bill would require the Secretary to restandardize the Federal DRG payment amounts by excluding, for discharges occurring after September 30, 1985, the reduced indirect medical education payment amounts based on the indirect teaching adjustment factors authorized by this provision (i.e., 8.1 percent in fiscal years

1986 and 1987, and 8.7 percent in fiscal years 1988 and thereafter) in place of the factor used under current law (i.e., 11.59 percent).

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with the modification that the Secretary will be required to restandardize the Federal DRG payment amounts effective for discharges occurring after September 30, 1986.

d. Reduce the standardized rates

House bill

The House bill requires that the Secretary restandardize the standardized payment amounts. In order to ensure that the budget neutrality calculation does not redistribute payment amounts among the twenty payment areas for which standardized payment amounts are calculated, the budget neutrality adjustment should be calculated to take into account the varying teaching payments in each of these regions. For each of these twenty payment areas, indirect teaching payments based on rates standardized to 8.1 percent curvilinear and paid out on the same basis (plus the disproportionate share payments) shall be neither more nor less than the payments based on rates standardized by 11.59 percent linear indirect medical education factor and paid out on 8.7 percent curvilinear basis.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with the modification that the reduction in the Federal DRG payment amounts will be effective for discharges occurring on or after October 1, 1986

e. Counting of non-employee interns

House bill

No Provision.

Senate amendment

In determining the indirect teaching adjustment, the Senate amendment would prohibit the Secretary from distinguishing between interns and residents who are employees of a hospital and those who furnish services to a hospital but are not employees of the hospital.

Conference agreement

The conference agreement includes the Senate amendment.

f. Intern and resident reimbursement limitations

House bill

No provision.

Senate amendment

Effective July 1, 1986, the Senate amendment would provide that interns and residents whose costs are not recognized as reasonable for the following reasons would not be counted in determining the indirect teaching adjustment: (1) those whose training exceeds the lesser of 5 years or the minimum number of years necessary to meet initial board eligibility requirements except, however, those who begin geriatric fellowship programs prior to July 1, 1991. After July 1, 1989, if the required number of years of training changes, the Secretary may change the number of years within specified limits; (2) for the year beginning July 1, 1986, one-third of those who are not graduates of accredited or approved schools of medicine, osteopathy, dentistry, or podiatry; for the year beginning July 1, 1987, two-thirds of those who are not graduates of such accredited schools; and for the year beginning July 1, 1988, none of those who are not graduates of such accredited schools; (3) for hospitals at which on October 1, 1985, more than 50 percent of their interns and residents were not graduates of accredited schools, one-third of such graduates for the 2 years beginning July 1, 1986, two-thirds of such graduates for the 3 years beginning July 1, 1988, and none of such graduates beginning July 1, 1991.

Conference agreement

The conference agreement does not include the Senate amendment.

g. Effective date

House bill

The House bill would be effective for discharges occurring on or after October 1, 1985.

Senate amendment

The Senate amendment provides an identical effective date.

Conference agreement

The Conference agreement includes the Senate amendment with the modification that the effective date will be March 1, 1986. In addition, the Secretary will be prohibited from implementing this provision until such time as the additional payments to disproportionate share hospitals are initiated.

5. Additional payment amounts for hospitals serving a disproportionate share of low income patients (sec. 105)

Present law

Under the Social Security Amendments of 1983, the Secretary of HHS is required to make adjustments to the PPS rates as the Secretary deems appropriate for hospitals that serve a disproportion-

ate number of low income or medicare part A patients. The Deficit Reduction Act of 1984 requires the Secretary, prior to December 1, 1984, to develop and publish a definition of disproportionate share hospitals, to identify such hospitals, and to make the list available to the Committees with legislative jurisdiction over part A. The Secretary has failed, to date, to develop any criteria for defining or identifying such hospitals or otherwise make any information available to the Committees.

House bill

a. Fiscal years 1986 and 1987 payments

For FY 1986 and FY 1987, the House bill would require the Secretary of HHS to make additional payments, by adjusting the Federal portion of the DRG payment, for eligible urban PPS hospitals with 100 beds or more, serving a disproportionate share of low income patients.

b. Eligible hospitals

The House bill would provide that such adjustment would be made to urban PPS hospitals with 100 or more beds meeting the disproportionate share criteria.

c. Low income patient definition

The proxy measure for low income would be the percentage of a hospital's total inpatient days attributable to medicaid patients (including medicaid-eligible medicare beneficiaries—medicare/medicaid crossovers).

d. Mandatory payment rate

The Federal portion of the DRG payment would be increased by .7 percent for each 1 percentage point increase in the ratio of low income inpatient days to total inpatient days, above the minimum threshold of 15 percent. The maximum adjustment would be 16 percent.

A limited exceptions process would be established for urban PPS hospitals with 100 beds or more. The Secretary would be required to make disproportionate share payments where a hospital can demonstrate that more than 30 percent of its net inpatient care revenue is provided by local or state governments for inpatient care for low income patients not otherwise reimbursed by medicare or medicaid. If this threshold is met, the per DRG add-on would be 16 percent. In no case would a hospital receive an adjustment greater than 16 percent.

This bill reduces the indirect teaching adjustment from 8.7 percent to 8.1 percent to reflect the disproportionate share adjustment. When the disproportionate share adjustment expires in two years, the indirect teaching adjustment would be increased for FY 1988 and beyond to 8.7 percent. The disproportionate share provision would be budget neutral and would be accomplished by restandardizing the standardized payment amounts.

e. Restandardization of DRG rates

The House bill would require the Secretary to restandardize the DRG payment amounts to reflect the disproportionate share adjustment.

f. Data development

No provision.

g. Data use for payment

No provision.

h. Discretionary payment add-on

No provision.

i. Waiver of Paperwork Reduction Act

No provision.

j. Effective date

The House bill would be effective for discharges occurring between October 1, 1985 and September 30, 1987.

*Senate amendment**a. Fiscal years 1986 and 1987 payments*

Similar provision, except that additional payments would be made to qualified urban or rural hospitals regardless of bed size.

b. Eligible hospitals

The Senate amendment provides that such additional payments would be made to any PPS hospital meeting the disproportionate share criteria.

c. Low income patient definition

The proxy measure for low income patients would be the percentage of a hospital's total medicare part A patient days attributable to medicare patients who are also enrolled in the Federal Supplemental Security Income (SSI) program.

d. Mandatory payment rate

For hospitals with 100 beds or more, the Federal portion of the PPS payment would be increased by 2 percent plus .25 percent for each 1 percentage point (or portion thereof) that the proxy measure is above the 15 percent minimum threshold. The maximum adjustment would be 12 percent. PPS rates for hospitals with less than 100 beds would be increased by 12 percent if their proxy measure is 55 percent or more.

e. Restandardization of DRG rates

No provision.

f. Data development

The Secretary would be required to develop accurate data on medicare patients who are also enrolled in SSI by October 1, 1986.

g. Data use for payment

The proposal also requires the Secretary to pay hospitals where historical data is not available on the basis of similar hospitals in the region in which the hospital is located.

h. Discretionary payment add-on

The Senate amendment would provide that disproportionate share payments may be made to a hospital based on data provided by the hospital if the Secretary agrees that such data is more accurate than the data which would otherwise be used.

i. Waiver of Paperwork Reduction Act

The Senate amendment would provide that the Paperwork Reduction Act would not apply to information required for purposes of carrying out this provision.

j. Effective date

The provision would be effective for discharges occurring on or after October 1, 1985, and before October 1, 1987.

Conference agreement

The conference agreement includes the House bill with the following modifications. Additional payments will be made to urban PPS hospitals with more than 100 beds if the hospital's percentage of low income patients is 15 percent or higher. For such hospitals, the Federal portion of the hospital's payment rate will be increased by 2.5 percent plus one-half of the difference between the hospital's percentage of low income patients and 15 percent, up to a maximum increase of 15 percent. The Federal portion of the payment rate will be increased by 5 percent for urban hospitals with less than 100 beds having a percentage of low income patients of 40 percent or higher. The increase will be 4 percent for rural hospitals with a percentage of low income patients of 45 percent or more.

The percentage of low income patients will be defined as the total number of inpatient days attributable to Federal Supplemental Security Income beneficiaries divided by the total number of medicare patient days, plus the number of medicaid patient days divided by total patient days.

Additional payments to qualified hospitals will be effective for discharges occurring on or after March 1, 1986 and before October 1, 1988.

The Congressional Budget Office is required to undertake a study of the impact of payments to disproportionate share hospitals and the advisability of providing additional payments to all "Pickle" hospitals, i.e., those which can demonstrate that more than 30 percent of their revenues are derived from State and local government payments for indigent care provided to patients not covered by

medicare or medicaid. The CBO is required to report the results of this study by January 1, 1987.

6. Treatment of certain rural osteopathic hospitals as rural referral centers (sec. 106)

Present law

Under present law, rural hospitals that meet certain requirements can qualify to receive the "urban standardized payment amount adjusted by the rural wage index applicable for the geographic area. The adjustment was permitted because data indicated that large rural hospitals with high case mix indices had costs which were similar to those of urban hospitals.

Under existing criteria there are approximately 146 rural referral centers. Each rural referral center is reviewed every three years by the Health Care Financing Administration to determine if the center continues to qualify. In order to qualify, a rural referral center must meet a specified case mix index, have at least 6,000 discharges in a cost reporting period, and meet other minor requirements.

House bill

The House bill would allow osteopathic hospitals to meet the rural referral center standard if they had at least 3,000 discharges in a cost reporting period and if they meet all the other requirements, as specified by the Secretary, for rural referral center designation. The provision would be effective for cost reporting periods beginning on or after the date of enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill. The conferees note that rural osteopathic hospitals wishing to qualify as rural referral centers must meet all other applicable requirements, in addition to the new discharge requirement established by this provision.

7. Return on equity capital for inpatient hospital services and other services (sec. 108)

Present law

A return on equity (owner) capital invested and used in providing patient care is considered a medicare allowable cost for proprietary, or for-profit, health care providers. Equity capital is the net worth of a hospital excluding those assets and liabilities not related to patient care. Specifically, equity capital includes: (1) the investment in the plant, property, and equipment (net of depreciation) related to patient care, plus deposited funds required in connection with leases; and (2) working capital maintained for necessary and proper operation of patient care facilities.

The level of payment for return on equity (ROE) formerly was set at a rate of no more than one and one-half times the average

rate of return on trust fund investments. In the Social Security Act Amendments of 1983 (P.L. 98-21), Congress reduced the level of payments for hospitals to the average rate of return on trust fund investments. The rate of return for other providers was not affected.

a. Hospital return on equity payments

House bill

The House bill would provide that return on equity would not be a medicare allowable cost for inpatient hospital services beginning October 1, 1986. In addition, costs attributable to a return on equity capital would be excluded in determining national and regional DRG prospective payment rates adjusted to include capital costs.

The bill would be effective with respect to cost reporting periods beginning on or after October 1, 1986, and to DRG payments for discharges on or after October 1, 1986.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with the modification that payments to hospitals for return on equity capital will be separated from payments for other elements of capital costs and phased out over a three-year period. For hospital cost reporting periods beginning in fiscal year 1987, payments for return on equity will be reduced to 75 percent of the otherwise allowable amount. For cost reporting periods beginning during fiscal years 1988 and 1989, return on equity payments will be reduced to 50 percent and 25 percent, respectively, of the otherwise allowable amounts.

The conferees expect that next year the Congress will review the entire issue of the method by which capital expenses of hospitals are reimbursed. At that time, the Congress will review, and may change, the provisions in this Act regarding return on equity.

b. Other provider return on equity payments

House bill

The House bill would reduce the rate of return for other provider services, if regulations provide for ROE, to the average rate of return on the hospital insurance trust fund beginning October 1, 1985.

The bill would be effective with cost reporting periods beginning on or after October 1, 1985.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification. The effective date would be March 1, 1986.

8. *Continuation of medicare reimbursement waivers for certain hospitals subject to regional hospital reimbursement demonstrations (sec. 109)*

Present law

Section 1886(c) permits a permanent waiver of the standard medicare reimbursement rules for States whose hospital cost containment programs meet a number of requirements, including the requirement that the costs under the State program not exceed those that would have been incurred without the waiver.

House bill

The House bill would permit a local hospital reimbursement system that had operated under a waiver to continue if the State requested the continuation and if the local project meets the requirements for States that receive a waiver, with the following change.

Such a system would have to include substantially all acute care hospitals in the area, and review a minimum of 75 percent of all revenues or expenses there for inpatient hospital services and 75 percent of revenues or expenses for inpatient hospital services provided under the state's plan approved under title XIX. Medicare's costs could not exceed what they otherwise would be under the medicare PPS systems.

This option would be limited to reimbursement systems that were carrying out a demonstration on January 1, 1985 with the approval of the Secretary of Health and Human Services. This provision would become effective upon enactment.

Senate amendment

Similar provision except (a) requires the Secretary to approve such a waiver request and (b) includes demonstrations authorized under section 402 of the Social Security Amendments of 1967 (as amended by section 222(b) of the Social Security Amendments of 1972).

Conference agreement

The conference agreement includes the Senate amendment with a modification to strike the language concerning the effective date.

In addition, the conference agreement will extend the demonstration project known as "Assessment for Community Care Services" through September 30, 1986. The conferees note that this project, carried out by Monroe County Long Term Care Program, Inc. has pioneered in the development of home based alternatives to hospital and nursing home use which allow the delivery of more appropriate and economical care to medicare beneficiaries.

9. *Four-year test for State waivers for certain States (Sec. 110)*

Present law

Under present law, States may request a waiver of medicare's reimbursement rules for a statewide hospital reimbursement control system under section 1886(c) of the Social Security Act. A number of requirements must be met before such a waiver request is grant-

ed. One requirement is that the State demonstrate, to the Secretary of the Department of Health and Human Services' satisfaction, that the amount of medicare payments made under the waiver would not exceed the amounts that otherwise would have been paid over a 36-month period under Title XVIII, if the State were not under a statewide reimbursement waiver.

House bill

The House bill would extend the 36-month test period under section 1886(c)(1)(C) for a further 12 months. Therefore, the comparison period would be a 48-month period. The provision would apply only to States which had made a request for a waiver under 1886(c) prior to December 31, 1984, and whose request was approved. The Secretary would be prohibited from discontinuing payments under the State's system because the Secretary has reason to believe that the assurances for meeting cost effectiveness tests are not being (or will not be) met before July 1, 1986. The only State that meets these criteria is New Jersey. The provision would be effective upon enactment.

Senate amendment

The Senate amendment would prohibit the Secretary from discontinuing a State's waiver so long as the State takes appropriate steps by July 1, 1986, to assure the Secretary that its system will continue to meet the cost-effectiveness test. The provision would apply only to States which had made a request for a waiver under 1886(c) prior to December 31, 1984. The provision would be effective upon enactment.

Conference agreement

The conference agreement includes the House bill.

10. Special rule for treatment of depreciation and capital indebtedness for donations of State property to non-profit corporations (sec. 111)

Present law

Section 2314 of the Deficit Reduction Act of 1984 (DEFRA), P.L. 98-369, limited the basis for which medicare depreciation is allowed when a change of ownership occurs. The new owner's basis is the lesser of (1) the historical cost, net of depreciation (cost to the previous owner), or (2) the purchase price.

House bill

The House bill would provide a special rule for treatment of certain transfers. In the case of a hospital or skilled nursing facility that is donated by a State government (donor) to a non-profit corporation (donee), the basis from which capital-related costs to the donee is calculated would be the donor's historical cost (net of depreciation).

The provision would be effective as if it had been included originally in DEFRA.

Senate amendment

Similar provision, except it applies only to hospitals.

Conference agreement

The conference agreement includes the Senate amendment.

11. Report on impact of outlier and transfer policy on rural hospitals (sec. 112)

Present law

Present law requires that additional payments be made under the prospective payment system for hospitals when there is either an unusually long length of stay or the stay is excessively costly (both as defined by the Secretary).

House bill

The Secretary of Health and Human Services would be required to review the impact of the outlier and transfer policies under the PPS system as they relate to rural hospitals, particularly rural hospitals with less than 100 beds.

The Secretary would be required to report to Congress on findings of the review not later than May 1, 1986, and should include in this report recommendations on changes in these policies to the extent that they adversely affect rural hospitals. The provision would be effective upon enactment.

Senate amendment

No provision

Conference agreement

The conference agreement includes the House bill with a modification to change the due date of the report to October 1, 1986.

12. Information on impact of PPS payments on hospitals (sec. 113)

Present law

Under the Congressional Budget Act of 1974, the Congressional Budget Office (CBO) is entitled to the most recently available cost reports submitted by medicare participating hospitals to the Department of Health and Human Services. There is no requirement that the House of Representative's Committee on Ways and Means or the Senate's Committee on Finance receive cost report information on hospitals that participate in the medicare program.

House bill

The House bill would require the Secretary of Health and Human Services to make available to the Prospective Payment Assessment Commission (ProPAC), the Congressional Budget Office, the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate, the most current information on the payments being made under the prospective payment system to individual hospitals.

The hospital specific information would be treated as confidential and would not be subject to further disclosure in a manner that

would permit the identification of individual hospitals. The provision would be effective upon enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill, with a modification to omit the House Committee on Ways and Means and the Senate Committee on Finance from, and to add the Congressional Research Service and the General Accounting Office to, the list of entities to receive current PPS payment information.

13. Indirect teaching adjustment related to independent clinic activities (sec. 710)

Present law

For the first three years of the prospective payment system (PPS), a special exception is applied to hospitals which had traditionally been allowed direct billing under part B so extensively that it would have been disruptive to immediately require them to bill for all such services under part A. These hospitals are, in effect, allowed to have part of their PPS payments paid through part B billings and the remainder paid to the hospital under part A. The Health Care Financing Administration has ruled that in such split payment cases, the indirect teaching adjustment would apply only to the portion of the medicare payment that is paid through part A.

House bill

No provision.

Senate amendment

The provision would clarify that the split payment provision was only intended to provide a temporary billing accommodation for certain hospitals and that the indirect teaching adjustment should be applied as if the entire PPS payment had been made under part A. The provision would be effective upon enactment.

Conference agreement

The conference agreement includes the Senate amendment, with the following modifications. Part A services billed under part B under a waiver granted under this authority will be paid at 100 percent of the reasonable charge (or other applicable basis of payment) and the entity billing such services under part B must accept such payment as payment in full. Payment of the indirect teaching adjustment as if all services were billed under the PPS payment methods in part A, will be effective with the first hospital cost reporting period beginning on or after January 1, 1986. Payment on part A services billed under part B at 100 percent of reasonable charges and the requirement that the billing entity accept such payment as full payment will be effective for services provided on or after 10 days following enactment.

14. Coverage of psychologists' services (sec. 711)

Present law

Section 1861(b) of the Social Security Act includes the definition of the inpatient hospital services that are paid for by medicare "such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements.

House bill

No provision.

Senate amendment

The provision would clarify that inpatient hospital services for which payments may be made under medicare part A would include diagnostic or therapeutic services provided by a psychologist. The provision would be effective upon enactment.

Conference amendment

The conference amendment does not include the Senate amendment.

15. Payments to sole community hospitals (sec. 711C)

Present law

Public Law 98-21 provided a special PPS payment formula for hospitals known as sole community hospitals that, due to special circumstances such as isolated location, are the sole source of inpatient services reasonably available in a given geographic area. Such hospitals are paid on the basis that all other PPS hospitals are paid during the first year of the transition period: 75 percent based on the hospital specific rate and 25 percent on the national DRG rate. Unlike other hospitals under PPS, which will eventually be paid totally according to a national DRG rate, sole community hospitals will remain at the 75/25 ratio.

In a suit filed in 1984, Redbud Community Hospital, a sole community hospital in Clearlake, CA, challenged HHS's determination of its PPS rate, arguing that the rate did not take into account the costs of providing several new services that were incurred subsequent to its base year. The United States District Court for the Northern District of California issued a preliminary injunction on July 30, 1984, directing the HHS Secretary to issue regulations taking into account any extraordinary and unusual costs not necessarily reflected in a hospital's base year costs but which, if not considered in estimating the hospital specific rate, were likely to result in a distortion in that rate, and taking into account the special needs of sole community hospitals and the unique effects of their status on the hospital specific rate. HHS issued such regulations on July 1, 1985, but withdrew them on July 31, 1985, after Supreme Court Justice William Rehnquist stayed the order of the U.S. District Court. There is a small number of other sole community hospitals that also consider their PPS payments to be inadequate be-

cause of costs incurred subsequent to their base year due to the addition of new facilities or services.

House bill

No provision.

Senate amendment

a. Payment provision

The Senate amendment would require the Secretary to provide an adjustment to the PPS rates to reasonably compensate sole community hospitals that experience a significant increase in operating costs in cost reporting periods after the base period due to the addition of new inpatient facilities or services (including the opening of a special care unit). Such payment adjustment would be applied to the cost reporting period during which the cost increase was incurred and to subsequent cost reporting periods as may be necessary to reasonably compensate the hospital for the increased costs.

b. Study

The Senate amendment would require the HHS Secretary to complete a study by January 1, 1987, of the effects of this provision, including recommendations on a permanent mechanism for needed expansions of sole community hospitals' services and the hospital specific rates of such hospitals.

The provision would be effective for payments for cost reporting periods beginning on or after October 1, 1983. The provision would expire on September 30, 1989.

Conference agreement

The conference agreement includes the Senate amendment but deletes the language relating to case mix changes, which is superfluous. The conferees intend that this provision will remedy problems for hospitals such as Redbud that have added new inpatient services subsequent to their base years.

16. Sense of the Senate with respect to inpatient hospital deductible (sec. 711B)

Present law

The Secretary of HHS announced that the inpatient hospital deductible for calendar year 1985 will be \$492.

Medicare law specifies the formula to be used to determine the inpatient hospital deductible amount, based on the average costs of a day of hospital care. Reduced lengths of stay and lower hospital occupancy rates have reduced costs per admission but have increased the costs of care per day.

House bill

No provision.

Senate amendment

Expresses the sense of the Senate that the Committee on Finance should report legislation on the annual increase in the deductible so that it is more consistent with annual increases in medicare payments to hospitals. The provision would be effective upon enactment.

Conference agreement

The conference agreement includes the Senate amendment, with the understanding that this provision expresses only the sense of the Senate.

*17. Promulgation of inpatient hospital deductible (sec. 716A)**Present law*

The Secretary of HHS announced on September 30, 1985, that the inpatient hospital deductible for calendar year 1986 will be \$492, an increase of 23 percent over the corresponding 1985 figure. Medicare law specifies the formula to be used to determine the deductible amount.

The Secretary must publish a notice of the projected increase by October 1 of each year.

House bill

No provision.

Senate amendment

The Senate amendment requires the Secretary to publish a notice of the projected increase by September 15 of each year. This provision would be effective for calendar years after 1985.

Conference agreement

The conference agreement includes the Senate amendment.

*18. ProPAC expansion (sec. 142 and 734)**Present law*

The Social Security Amendments of 1983 (P.L. 98-21) provided for the establishment of the Prospective Payment Assessment Commission (ProPAC) consisting of 15 members appointed by the Director of the Office of Technology Assessment, generally to serve for 3-year terms.

House bill

The House bill would expand current ProPAC membership by two, to be appointed no later than January 1, 1986. (See item 40 also for provisions relating to physician payment activities or ProPAC.)

Senate amendment

The provision would expand ProPAC membership by two, to be appointed no later than 60 days after enactment, for 3-year terms. This provision would become effective upon enactment.

Conference agreement

The conference agreement includes the Senate amendment. It is the intent of the conferees that the two new ProPAC members would represent nurses and rural hospitals.

19. Extension and payment for hospice care (sec. 121)

Present law

Under current law, individuals who are entitled to medicare part A benefits and who are certified to be terminally ill may elect to receive part A reimbursement for hospice care services, in lieu of certain other services. Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which authorized this hospice benefit, mandated reports to the Congress by the Secretary of Health and Human Services on September 30, 1983, (regarding the Department's hospice demonstration project) and January 1, 1986 (evaluating the hospice benefit). Current authority for the medicare hospice benefit is scheduled to sunset on October 1, 1986.

In implementing the TEFRA hospice benefit, the Department of Health and Human Services established a prospective payment system and set daily rates for each of four levels of hospice care. Public Law 98-617 increased the routine home care payment rate by approximately \$7.00 per day for the fiscal year beginning October 1, 1984, and required the Secretary of HHS to review and adjust the hospice rates annually, beginning October 1, 1985.

The report on the hospice demonstration project, which was to have been submitted by September 30, 1983, has not been received by the Congress. Cost data will not be available to the Secretary in order for the rates to be updated by October 1, 1985.

House bill

The bill would repeal the sunset provision of present law. Beginning January 1, 1986, each of the daily payment rates for hospice care would be increased by \$10.00, an amount which is slightly less than the Congressional Budget Office estimate of the savings per day attributable to a medicare hospice election. The Secretary would be given one additional year, until October 1, 1986, to review and adjust the hospice rates and to report to the Congress on the adequacy of the rates in insuring participation in medicare by an adequate number of hospice programs. The repeal of the sunset provision would be effective on enactment of the bill.

Senate amendment

Identical provision.

Conference agreement

The conference agreement includes the House bill.

20. Limiting the penalty for late enrollment in part A (sec. 122)

Present law

Part A coverage under medicare is available on a voluntary basis to individuals 65 or over who are not otherwise entitled to coverage. These individuals may obtain medicare part A coverage by

paying a monthly premium. Anyone purchasing part A coverage after the third month after the month in which he becomes eligible is charged a late penalty of 10 percent of the standard premium for each 12 months he is late in enrolling; that is, for each 12 months during which he could have been, but was not enrolled. This penalty is paid each and every month of coverage for the rest of the beneficiary's life.

House bill

The House bill would limit the part A premium penalty to 10 percent no matter how late an individual enrolled, and the period during which the penalty is paid would be limited to twice the number of years enrollment was delayed. At the end of this period, the premium would revert to the standard monthly premium in effect at that time. For example, if the individual enrolled one year late, the penalty would be 10 percent paid for two years; for late enrollment for two years, the penalty would be 10 percent a year for four years, and so on, after which it would revert to the standard premium amount.

The House bill would also apply to medicare beneficiaries currently paying a part A premium penalty. Months before, during or after January 1986, in which such an individual was required to pay a premium penalty, would be taken into account in determining the month in which the premium would no longer be subject to a penalty increase.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill, with a modification that the effective date will be April 1, 1986.

21. Medicare coverage of, and application of hospital insurance tax to, newly-hired state and local government employees (sec. 123)

Present law

Under present law, there is no Federal requirement that state and local government employees pay the hospital insurance tax. Most state and local government employment is already covered as a result of voluntary agreements for such coverage entered into by the States. About 25-30 percent of such employment is not currently covered.

House bill

The House bill would extend medicare coverage on a mandatory basis for all state and local government employees hired subsequent to December 31, 1985. The employers and their employees would become liable for the hospital insurance portion of the FICA tax and the employees would earn credit toward medicare eligibility based on their covered earnings.

Senate amendment

The Senate amendment is similar, but would include current, as well as newly hired, employees and would become effective October 1, 1986.

22. *Responsibilities of medicare hospitals in emergency cases (sec. 124)*

Present law

Hospitals that participate in medicare have to meet defined conditions of participation and enter into participation agreements. The participation agreement contains no specific requirements relating to the appropriate treatment of emergency patients, including non-medicare patients.

a. Requirements

(1) Medical screening

House bill

The House bill would require all participating hospitals with emergency departments to provide an appropriate medical screening examination for any individual who requests it (or has a request made on his behalf) to determine whether an emergency medical condition exists or if the patient is in active labor.

Senate amendment

The Senate amendment contains a similar provision, except it would require such examination or treatment only if it is within the capability of the hospital's emergency department. In addition, it provides that these medical screening requirements would not apply if providing a medical screening examination would delay or otherwise be contrary to prompt medical treatment of the individual's medical condition.

Conference agreement

The conference agreement includes the Senate amendment's provision that such examination or treatment is required of the hospital only if it is within the capability of the hospital's emergency department; the conference agreement does not include the Senate amendment's provision that the medical screening requirements would not apply if they would delay or be contrary to prompt treatment.

(2) Necessary stabilization

House bill

The House bill provides that all participating hospitals must, when a patient is found to have an emergency condition or to be in active labor (i) provide further examination and treatment within their competence to stabilize the medical condition or provide treatment for the labor, unless such treatment is refused, or (ii) provide an appropriate transfer to another medical facility in accordance with a defined standard.

Senate amendment

The Senate amendment contains a similar provision, except that such a determination could be made through an appropriate medical screening examination or otherwise. In addition, the Senate amendment does not require the hospital to provide for transfer to another medical facility if the transfer is refused.

Conference agreement

The conference agreement includes the House bill's language concerning the hospital's determination of an emergency medical condition or active labor. The conference agreement includes the Senate amendment's provision that transfer is not required if refused, with a clarifying amendment that examination, treatment or transfer could be refused by either the patient or a person responsible for the patient. The conference agreement also provides that if the individual (or a legally responsible person acting on the individual's behalf) refuses further medical examination and treatment or refuses a transfer, the hospital's obligation with respect to further examination and treatment or with respect to transfer is discharged.

(3) Restricting transfers until patient is stabilized

House bill

A hospital may not transfer a patient who has not been stabilized or is in active labor unless: (i) a physician has signed a certificate that, based on the information available at the time and using reasonable standards, the medical benefits to be obtained from appropriate medical treatment at another facility outweigh the risks of transfer, and (ii) the transfer is an appropriate transfer, i.e., the receiving facility has agreed to accept the patient, has space and qualified personnel available for his treatment and is provided with medical examination and treatment records from the transferring hospital, and the transfer is made by proper personnel using equipment that meets health and safety standards.

Senate amendment

The Senate amendment includes a similar provision, except prohibits a hospital from transferring a patient who has not been stabilized or is in active labor unless: (i) the patient (or member of the patient's family if the patient is an unemancipated minor or is unable to communicate) or (ii) a physician or other qualified medical personnel when a physician is not available in the emergency department has made a determination that the benefits of a transfer outweigh the risks, and (iii) the transfer is an appropriate transfer.

Conference agreement

The conference agreement includes the Senate amendment provision conditioning a transfer on patient (or member of the patient's family) approval, with an amendment that a person legally responsible for the patient could also request a transfer. The conference agreement includes the House bill provision requiring physician

certification for transfer, but includes the Senate amendment provision that such certification could also be made by other qualified medical personnel when a physician is not (adding the word "readily") available in the emergency department.

(4) Definition of an appropriate transfer

House bill

Defines an appropriate transfer as one:

(i) in which the receiving facility has available space and qualified personnel for the treatment of the patient, has agreed to accept transfer of the patient and to provide appropriate medical treatment, and is being provided appropriate medical records (or copies) of the examination and treatment provided by the transferring facility;

(ii) in which the transferring hospital provides the receiving hospital with appropriate medical records (or copies) of the examination and treatment effected at the transferring hospital;

(iii) in which the transfer is made through qualified personnel and transportation equipment, including medically appropriate life support measures during the transfer; and

(iv) which meets other requirements the Secretary of HHS may find necessary.

Senate amendment

The Senate amendment contains a similar provision except:

(i) also provides that if the patient's medical condition is sufficiently serious to require an immediate transfer, the receiving facility must be notified of the transfer as soon as practicable under the circumstances;

(ii) no provision;

(iii) provides that the transfer be made by qualified personnel and transportation equipment as required, including necessary and medically appropriate life support measures; and

(iv) identical provision.

Conference agreement

The conference agreement includes:

(i) the House bill, which does not include notification of the transfer as soon as practicable;

(ii) the House bill, which requires the transferring hospital to provide the receiving hospital with appropriate medical records; and

(iii) the Senate amendment regarding qualified personnel and transportation equipment.

b. Enforcement

House bill

The House bill provides that a hospital that fails to meet these requirements would have its medicare participation agreement terminated. In addition, a participating hospital that knowingly violates these requirements and the responsible physician in the hospital with respect to such a violation are each subject to a civil

monetary penalty of not more than \$25,000 for each violation. For purposes of this section, a "responsible physician" means a physician who is employed by, or under contract with, the participating hospital, and acting as such an employee or under such contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual with respect to which the violation occurred.

Any person who suffers personal harm, and any medical facility which suffers a financial loss as a direct result of a participating hospital's violation of these requirements, may bring a civil action, in an appropriate Federal district court, against the participating hospital, for damages and other appropriate relief. No civil action may be brought more than two years after the violation.

Senate amendment

The Senate amendment provides that if a hospital knowingly and willfully, or negligently, fails to meet the requirements of this provision, the hospital would be subject to (1) termination of its medicare provider agreement, or (2) at the option of the Secretary, suspension of the medicare provider agreement for an appropriate length of time, as determined by the Secretary, after reasonable notice to the hospital and to the public.

Conference agreement

The conference agreement includes the House bill, with a modification to permit the Secretary to terminate or suspend a hospital's provider agreement for "knowingly and willfully or negligently" failing to meet the requirements of this provision in addition to the civil monetary penalties and civil enforcements.

The civil enforcement provision was restructured to clarify its application. In addition, the courts are directed, on the issue of damages, to apply the law of the State in which the violating hospital is located, for actions brought by a harmed individual or a hospital which suffers a financial loss. The language allowing courts to grant "other appropriate relief" was also modified to read "other equitable relief as appropriate", to give the courts clearer direction that such relief should be within the courts regular equitable powers and should be granted for the purpose of remedying the violation or deterring subsequent violations.

c. Definitions

(1) Emergency medical condition

House bill

The House bill defines "emergency medical condition" to mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that lack of immediate medical attention could result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Senate amendment

The Senate amendment contains an identical definition.

(2) Active labor

House bill

The House bill defines "active labor" to mean labor when delivery is imminent, there is inadequate time to safely transfer the patient to another hospital, or a transfer could threaten the health and safety of the patient or the unborn child.

Senate amendment

The Senate amendment includes a similar definition, except provides that there is inadequate time to safely transfer the patient prior to delivery, and does not include that a transfer could threaten the health and safety of the patient or the unborn child.

Conference agreement

The conference agreement includes the House bill provision concerning the threat to the health and safety of the patient or unborn child and the Senate amendment provision regarding inadequate time to transfer prior to delivery.

(3) Participating hospital

House bill

The House bill defines "participating hospital" to mean a hospital that has a provider agreement under section 1866 of medicare and has obligated itself to comply with the requirements of this provision.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House definition of "participating hospital."

(4) To stabilize

House bill

The House bill defines "to stabilize" to mean, with respect to a medical condition, to provide such medical treatment of the condition as may be necessary to assure that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

Senate amendment

The Senate amendment defines "to stabilize" to mean, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary under the circumstances and within the capability of the hospital (A) so that the transfer of the individual will not, within reasonable medical probability, result in substantial risk of death or serious impairment as a direct result of the transfer, or (B) in order to determine that the benefits obtained from providing appropriate medical treatment at another medical facility, taking into account potential risks in-

volved in the transfer, outweigh the potential benefits to the individual's medical condition from not affecting the transfer.

Conference agreement

The conference agreement includes the House bill with two modifications from the Senate amendment: the condition must be an emergency medical condition, and the assurance that no material deterioration of the medical condition is likely to result must be within reasonable medical probability.

(5) Stabilized

House bill

The House bill defines "stabilized" to mean, with respect to a medical condition, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

Senate amendment

The Senate amendment defines "stabilized" to mean, with respect to an emergency medical condition, that such medical treatment has been provided as may be reasonably necessary under the circumstances and within the capability of the hospital (A) so that the transfer will not, within reasonable medical probability, result in substantial risk of death or serious impairment as a direct result of the transfer, or (B) in order to determine that the benefits obtained from providing appropriate medical treatment at another medical facility, taking into account potential risks involved in the transfer, outweigh the potential benefits to the individual's medical condition from not affecting the transfer.

Conference agreement

The conference agreement includes the House bill with the same two modifications described in Item (4) above.

(6) Transfer

House bill

The House bill defines "transfer" to mean the movement (including discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such movement of a patient who has been declared dead or leaves the facility without the permission of any such person.

Senate amendment

The Senate amendment contains an identical definition.

d. Preemption

House bill

The House bill provides that this provision does not preempt State or local law requirements respecting hospitals, except if such requirements directly conflict with a requirement of this provision.

Senate amendment

The Senate amendment contains a similar provision, except does not specify that the State or local law requirements must apply only to hospitals.

Conference agreement

The conference agreement includes the Senate amendment.

*e. GAO study**House bill*

No provision.

Senate amendment

The Senate amendment requires the Comptroller General to conduct a study, and report to Congress within 2 years after enactment, on problems created by hospitals that transfer patients without providing necessary emergency medical treatment. The study must include a survey and assesment of the extent of the problems; a survey of the available remedies to such problems and an assessment of the frequency and effectiveness with which such remedies are utilized; an assessment of the effectiveness of the remedy provided by this new provision; and recommendations for changes in Federal law, including medicare and possibly medicaid.

Conference agreement

The conference agreement does not include the Senate amendment.

*f. Regulations**House bill*

No provision.

Senate amendment

The Senate amendment requires the Secretary of HHS to promulgate final regulations to implement this new provision within 180 days of enactment, and to report to Congress on the methods to be used for monitoring and enforcing compliance with this provision.

Conference agreement

The conference agreement does not include the Senate amendment regarding regulations, but does include the Senate amendment requiring the Secretary to report to Congress on monitoring and enforcement within 6 months after the enactment date.

*g. Effective date**House bill*

The House bill provides an effective date of October 1, 1985.

Senate amendment

The Senate amendment provides an effective date of April 1, 1986.

Conference agreement

The conference agreement includes the modification that the effective date would be 90 days after enactment.

*23. Improve access to skilled nursing facilities (sec. 722)**Present law*

Medicare provides skilled nursing facility (SNF) services under the Hospital Insurance (Part A) program.

a. Payment rates.—SNF's are reimbursed on the basis of reasonable costs actually incurred, subject to limits. Medicare's final payment to a SNF is determined retrospectively only after a SNF has itemized its costs for a full year on a medicare cost report. Separate reimbursement limits are applied to freestanding SNFs and hospital-based SNFs. For freestanding facilities, limits are established at 112 percent of the mean operating cost of urban and rural freestanding facilities respectively. Limits for urban hospital-based facilities are equal to the urban freestanding facility limits plus 50 percent of the difference between the freestanding limit and 112 percent of mean operating costs for hospital-based facilities. A similar calculation, based on costs of rural facilities, is made for rural hospital-based facilities. Cost differences between hospital-based and freestanding facilities attributable to excess overhead allocations resulting from medicare reimbursement principles are recognized as an add-on to the limit for hospital-based facilities.

b. Waiver of liability.—Current medicare law allows part A providers to collect payment from intermediaries after a claim has been denied because the items or services were found not to be medically reasonable and necessary or because services were determined to be custodial care. A finding must be made that neither the beneficiary nor the provider knew or could reasonably have been expected to know that the items or services were not covered. However, providers can earn a presumption, or waiver, that allows them not be held liable for uncovered services they provided if the provider meets five procedural criteria. By meeting the criteria, providers are essentially presumed not to have known that the service would not be covered and their liability for paying for that service therefore can be waived. This is often referred to as the "waiver of liability." Under current administrative practice, a SNF is judged to meet these criteria and to have its liability for certain uncovered claims waived if its denial rate does not exceed 5 percent. The denial rate is determined by the percentage of days billed by the provider as covered that HCFA later determines to be non-covered when the bill is reviewed. Under the waiver policy, SNFs with a denial rate of 5 percent or less are paid for these denied services.

In a proposed rule published February 12, 1985, HCFA would eliminate the criteria for a favorable presumption and determine payment on a case-by-case basis. Under the rule, SNFs would be

liable for payment for 100 percent of all claims which were judged to be uncovered after HCFA review.

House bill

No provision.

Senate amendment

The Senate amendment provides that SNFs providing less than 1,500 days of care per year to medicare patients in the preceding year would have the option of being paid a prospective rate set at 105 percent of the regional mean for all SNFs in the region. The rate would be separately calculated for urban and rural areas and include all non-ancillary costs, including capital and return on investment if medicare pays SNFs for a return on equity capital. Those accepting the prospective rate would be required to file a minimal cost report. With respect to ancillary services, the Secretary would be allowed to pay for those services on the basis of reasonable costs or reasonable charges. The Secretary would be required to reduce the number of intermediaries to ten by April 1, 1987. The Secretary would be required to maintain the five percent favorable presumption waiver of liability until 30 months after enactment of this legislation. This provision would be effective upon enactment.

Conference agreement

The conference agreement includes the Senate amendment, with the following modifications. The prospective per diem rates will be adjusted to reflect wage differences between urban areas and between rural areas within each region. The prospective urban or rural regional per diem rate for a skilled nursing facility cannot exceed the per diem cost limit otherwise applicable to that facility, adjusted to include average urban or rural per diem capital costs and return on equity if medicare pays SNFs for a return on equity capital under the normal reimbursement rules. Thus, the SNF's prospective rate cannot exceed its cost limit adjusted for capital costs. Prospective payment on this basis will take effect for facilities that elect such payment for cost reporting periods beginning on or after October 1, 1986. The conference agreement does not require the Secretary to reduce the number of fiscal intermediaries serving skilled nursing facilities.

24. Limitation on direct medical education payments (sec. 107)

Present law

On July 5, 1985, the Administration issued final regulations freezing the amount medicare reimburses providers for their direct costs of approved medical education activities, for cost reporting periods beginning on or after July 1, 1985.

The freeze permits payment based on the lesser of a provider's allowable direct medical education costs for the current cost reporting period or for a base year (the provider's cost reporting period beginning on or after October 1, 1983), adjusted for changes in medicare utilization.

House bill

The House bill would retroactively prohibit implementation of the regulations imposing the one-year freeze.

Senate amendment

a. Payment level

The Senate amendment would limit payments to hospitals for their direct costs of approved medical education activities for the first cost reporting period beginning on or after July 1, 1985. The limit would be the provider's approved medical education costs during the cost reporting period ending prior to October 1, 1985, updated to reflect general increases in the cost of approved medical educational activities which took place between the end of the prior accounting period and the beginning of the freeze accounting period.

b. Residency year limitation

Beginning with the first cost reporting period beginning on or after July 1, 1986, the direct costs of medical education activities associated with those residents who are either board eligible or have completed more than five years of training will no longer be allowable, with the exception of geriatric fellowships which meet criteria established by the Secretary. The exception for geriatric fellowships expire July 1, 1991.

c. Limitations regarding certain foreign medical graduates

Also beginning with a hospital's first cost reporting period beginning on or after July 1, 1986, only 66 percent of the direct educational costs of graduates of medical schools not accredited by the Liaison Committee on Medical Education (LCME), or graduates of accredited schools of osteopathy, dentistry, or podiatry will be considered for allowable cost determinations. The allowable percent for these so-called "foreign medical graduates" would be reduced to 33 percent in the subsequent reporting period and to zero percent thereafter.

d. 1986-1987 payments

For the year beginning July 1, 1986, the amounts recognized as reasonable would include, on an average cost per intern and resident basis, the lesser of (1) two-thirds the number of interns and residents who are not graduates of such accredited schools but who began their formal training required for initial board eligibility in their specialty prior to July 1, 1986, or (2) two-thirds the number of interns and residents who are not graduates of such accredited schools but for whom the hospital received direct medical education payments from medicare for the year beginning July 1, 1985.

e. 1987-1988 payments

For the year beginning July 1, 1987, the amounts recognized as reasonable would include, on an average cost per intern and resident basis, the lesser of (1) one-third the number of interns and

residents who are not graduates of such accredited schools but who began their formal training required for initial board eligibility in their specialty prior to July 1, 1986, or (2) one-third the number of interns and residents who are not graduates of such accredited schools but for whom the hospital received direct medical education payments from medicare for the year beginning July 1, 1985.

f. Special 50 percent foreign medical graduate rule

Hospitals whose unaccredited medical school graduates represent more than 50 percent of their students as of October 1, 1985, would receive the 66 percent funding for the first two reporting periods beginning on or after July 1, 1986, 33 percent funding for the three subsequent periods, and no funding thereafter. The provision also requires the Secretary and the General Accounting Office to study and report on various aspects of graduate medical education. The provision would be effective for cost reporting periods beginning on or after July 1, 1985.

g. Nursing and other health professions study

The Senate amendment would require the Secretary to conduct a study and report to Congress prior to December 31, 1986, on approved nursing and other health professions educational activities for which medicare reimburses hospitals. The study must address data on the types of such programs and the number of programs and students; relationships between hospitals and the schools with which the programs are affiliated; the types and amounts of expenses for which reimbursement is made; and the financial and other contributions which accrue to the hospital as a consequence of having such programs.

h. Geriatric fellowship study

The Senate amendment would require the Secretary to conduct a study and report to Congress prior to July 1, 1990, on (1) the advisability of continuing the exemption for geriatric fellowships from the limitation on years of training for purposes of determining medicare payments for direct medical education costs, (2) the advisability of expanding the exemption to cover other educational activities, and (3) the adequacy of the supply of faculty in the field of geriatrics.

i. GAO study

The Senate amendment would require the General Accounting Office to conduct a study and report to Congress prior to December 31, 1986, on differences in medicare payments to teaching versus nonteaching hospitals, identifying the components of such payments and accounting, to the extent feasible, for any differences between the amounts of the payment components in teaching and nonteaching settings. It would provide that GAO may use a sample of teaching hospital patients and other data sources deemed appropriate, and would require GAO to control to the extent feasible for differences in a number of factors which could affect the comparability of patients and of payments between teaching and nonteach-

ing settings. It would require that this study be coordinated with the study of teaching physicians' services required under section 2307(c) of the Deficit Reduction Act of 1984.

j. Waiver of Paperwork Reduction Act

The Senate amendment would provide that Chapter 35 of Title 44, U.S. Code (Paperwork Reduction) would not apply to information required to carry out this provision.

Conference agreement

a. Payment level

The conference agreement includes the Senate amendment with a modification as follows.

Hospital-specific approved FTE resident amounts will be determined based on data on direct graduate medical education (GME) costs and numbers of interns and residents, from hospital cost reporting periods beginning in fiscal year 1984. These amounts will then be updated according to the specifications described in the July 5, 1985 regulation (amending 42 CFR Parts 405 and 412) limiting medicare payments for direct medical education costs; and will then be increased by an additional one percent.

This methodology replaces the current reasonable cost methodology for determining hospitals allowable costs, in calculating hospitals' medicare payments for graduate medical education activities. (Medicare will continue to reimburse hospitals on a cost basis for the direct medical education costs associated with nursing and allied health training activities. This amendment prohibits the Secretary from placing limitations on the allowable costs of such activities.)

A hospital's medicare payments will be determined by multiplying its approved FTE resident amount by the number of its full-time equivalent residents, and then by multiplying that product by the proportion of total inpatient days used by medicare patients.

For those hospitals whose cost reporting periods do not coincide with the normal July 1 through June 30 residency year, the hospital's FTE count will be determined by multiplying the number of FTE residents in the first residency year falling within the cost reporting period by the proportion of the residency period falling within that cost reporting period, and adding to this the number of FTE residents in the second residency year falling within the cost reporting period multiplied by the proportion of that residency year falling within the cost reporting period.

For hospitals' cost reporting periods beginning on or after July 1, 1986, the approved FTE resident amounts will be determined by applying the increase in the Consumer Price Index for Urban Consumers to the amounts allowed in the previous cost reporting period.

b. Residency year limitations

The conference agreement includes the Senate amendment with a modification as follows.

Limitations are placed on the way in which residents are counted toward full-time equivalency, once they have reached a specified point in their training. On or after July 1, 1986, hospitals will receive 100 percent of their approved FTE resident amounts for each year of a resident's training that is within the minimum number of years of formal training necessary to satisfy specialty requirements for initial board eligibility, plus one year, to a maximum of five years.

On or after July 1, 1986, and before July 1, 1987, medicare payment for training years exceeding these limits will be made at 75 percent of the rate that would otherwise be recognized. On or after July 1, 1987, payment will be made at 50 percent of the rate that would otherwise be recognized. Up to two years of training in a geriatric residency or fellowship program will be paid for at 100 percent of the rate that would otherwise be recognized, and will be excluded from the 5-year limit.

c. Limitations regarding certain foreign medical graduates

The conference agreement includes the Senate amendment with a modification as follows.

No limitations are applied with respect to medicare payment for approved FTE resident amounts for FMGs, except as follows. Effective July 1, 1986, an FMG will not be counted as a resident unless the individual has passed the Foreign Medical Graduate Examination in Medical Sciences (FMGEMS), except under specified circumstances. A one-year transition period is provided for current FMG residents. From July 1, 1986 through June 30, 1987, such an FMG will be counted as a resident at a rate equal to one-half of the rate at which the individual would otherwise be counted. An FMG who does not pass the FMGEMS during that year would not be counted at all during subsequent years, unless he or she later passed the test.

d. 1986-1988 payments

The conference agreement does not include the Senate amendment.

e. 1987-1988 payments

The conference agreement does not include the Senate amendment.

f. Special 50 percent foreign medical graduate rule

The conference agreement does not include the Senate amendment.

g. Nursing and other health professions study

The conference agreement includes the Senate amendment.

h. Geriatric fellowship study

The conference agreement includes the Senate amendment with a modification as follows.

The conferees note that the Secretary is required by Public Law 99-158 to conduct a study of Health Personnel Needs for the Elderly. The conferees direct the Secretary to coordinate that study with the one mandated by this act.

i. GAO study

The conference agreement includes the Senate amendment with a modification as follows.

The GAO is required to study the differences in the amounts of medicare payments made with respect to patients in teaching and nonteaching hospitals, and also to study variations in such payments across teaching hospitals, taking into account the same variables and factors.

j. Waiver of paperwork reduction act

The conference agreement includes the Senate amendment.

k. Part B billing

The conference agreement includes a requirement that the Secretary establish by July 1, 1987, a system which provides for a unique identifier for each physician who furnishes services for which payment may be made under medicare. This system is required in order to enable the Secretary to effectively enforce the current law prohibition on part B billing by interns and residents in approved training programs for services within the scope of those programs. This capability is of particular importance in light of the limits on allowable direct GME costs established by this legislation.

l. Report on uniformity of approved FTE resident amounts

The conference agreement includes a requirement that the Secretary report to Congress before December 31, 1987, on the advisability of revising approved FTE resident payment amounts across hospitals to provide for greater uniformity, and on how such revisions should be implemented if advised.

m. Study on foreign medical graduates

The conference agreement includes a requirement that the Secretary study and report to Congress by December 31, 1987 on the use of FMGs for the provision of health care services to medicare beneficiaries. The study should evaluate cost, quality and access issues with respect to services provided by FMGs, and should address the impact on costs of and access to these services in the event of a phase-out of medicare direct GME payments for FMGs.

n. Changes in cost allocation methods

Certain hospital reimbursement systems that received waivers from medicare have used methods of allocating administrative and general costs that are different from those required by the medicare hospital cost reporting forms. The conferees are concerned that, where these alternative allocation methods are in use, the base year direct GME costs used to determine the approved FTE

resident amounts established by other provisions of this legislation, may be understated.

The conferees direct the Secretary to permit changes in these alternative allocation methods. The conferees further direct the Secretary to adjust the regional standardized payment amounts and the hospital-specific amounts to account for the overstatement of these amounts due to the method of allocation of overhead used by teaching hospitals in the base period.

25. Moratorium on medicare laboratory payment demonstration

Present law

Pursuant to demonstration authority of present law, the Secretary has proposed to experiment with competitive bidding as a method of purchasing clinical laboratory services under the medicare program. Independent laboratories have expressed the concern that under the experiments, unsuccessful bidders might not be eligible to participate in the medicare program.

House bill

No provision.

Senate amendment

The provision would postpone the demonstrations until December 31, 1986 with the exception that the design of and site selection for such demonstrations can proceed. During this moratorium, representatives of the laboratory industry could conduct a study in collaboration with the Secretary and the U.S. General Accounting Office, to determine whether there is a less disruptive method of utilizing competitive market forces in setting medicare payment levels—e.g., by giving medicare access to laboratory fee schedules that have been established in competing for the business of other large purchasers. If the study is conducted, the Secretary and the GAO shall provide the study and their comments on it to the committees of jurisdiction. This provision would be effective upon enactment.

Conference agreement

The conference agreement includes the Senate amendment. It is the intent of the conferees that if a study is conducted the Secretary will assist the industry in the conduct of the study by providing data and technical assistance as necessary. The GAO's role is intended to be consultative rather than participatory with respect to the conduct of the industry study.

26. Extend home health waiver of liability

Present law

Present medicare law allows part A providers to collect payment from intermediaries after a claim has been denied because the items or services were found not to be medically reasonable and necessary or because services were determined to be custodial care. A finding must be made that neither the beneficiary nor the provider knew or could reasonably have been expected to know that

the items or services were not covered. Under current administrative practice, providers can be presumed to meet this test if they meet certain criteria. The principle criterion for home health agencies is that its denial rate does not exceed 2.5 percent. The denial rate is determined by the percentage of days billed by the provider as covered that HCFA later determines to be noncovered when the bill is reviewed. Under this waiver of liability policy, home health agencies with a denial rate of 2.5 percent or less are paid for these denied services.

In a proposed rule published February 12, 1985, HCFA would eliminate the criteria for a favorable presumption and determine payment on a case-by-case basis. Under the rule, home health agencies would be liable for payment for claims which were judged to be uncovered after HCFA review.

House bill

No provision.

Senate amendment

The provision would require the Secretary to maintain the 2.5 percent waiver of liability policy for home health agencies from the date of enactment until 12 months after the consolidation of claims processing for home health agencies, that is, when all ten home health agency fiscal intermediaries begin operations. This provision would be effective upon enactment.

Conference agreement

The conference agreement includes the Senate amendment.

27. Home health regulation moratorium

Present law

Prior to the recent publication of final regulations, reimbursement for home health services was limited to the 75th percentile of the average costs per visit incurred by all home health agencies. Separate limits were established for each type of service (e.g., skilled nursing, home health, and physical therapy); however, they were applied in the aggregate to each home health agency based on its mix of services.

The Administration has revised, in regulations published July 5, 1985, the home health cost limit methodology. For cost reporting periods beginning on or after July 1, 1985, the limits are set at 120 percent of the mean and would be applied separately to each type of service. For cost reporting periods beginning on or after July 1, 1986, the limits are to be reduced to 115 percent of the mean. For cost reporting periods beginning on or after July 1, 1987, the limits are to be set at 112 percent of the mean.

House bill

No provision.

Senate amendment

The provision would delay implementation of the July 5 regulations until July 1, 1986. The provision would become effective July 1, 1985.

Conference agreement

The conference agreement includes the Senate amendment with a modification as follows:

The modification specifies that for cost reporting periods beginning on or after July 1, 1985, the limits are set at 120 percent of the mean. For cost reporting periods beginning on or after July 1, 1986, the limits are to be set at 115 percent of the mean and for cost reporting periods beginning on or after July 1, 1987 the limits are to be set at 112 percent of the mean. The statute also directs the Secretary to provide for an adjustment to these limits as they apply to hospital-based home health agencies, to account for the higher administrative and general costs incurred by such agencies.

The Secretary is precluded from applying the limits separately for each type of service. Instead, the Secretary would be required to continue to allow agencies to aggregate these limits and apply them to aggregated costs. The Comptroller General is required to report to Congress by September 1, 1986 on the appropriateness of applying the cost limits discipline-by-discipline, rather than through aggregation. The conferees expect to examine this issue after submission of the GAO report.

28. Studies relating to physical therapists and other professionals

a. Study of physical therapists' office requirements

Present law

Under current law, part B of medicare covers the services of a qualified physical therapist in independent practice when furnished by him or under his direct supervision in his office or in the patient's home. These services must be prescribed by a physician and furnished pursuant to a written plan of treatment established by a physician or a qualified physical therapist.

The Secretary is required, under present law, to establish conditions that an independently practicing physical therapist must meet in order to receive medicare reimbursement. The Secretary, by regulation, requires that a physical therapist in independent practice maintain an office space with the necessary equipment to provide an adequate program of physical therapy. This requirement is applied even to those therapists who operate exclusively in the beneficiary's home.

House bill

No provision.

Senate amendment

The Senate amendment is required to study the requirement that independently practicing physical therapists who operate exclusively in beneficiaries' homes maintain fully-equipped offices.

The report would be due April 1, 1986. The provision would be effective upon enactment.

Conference agreement

The conference agreement includes the Senate amendment with a modification that specifies the report is due to Congress prior to October 1, 1986.

b. Study of home health agency supervision

Present law

The medicare law requires that a physician or registered nurse supervise patient care services provided by a home health agency.

House bill

No provision.

Senate amendment

The Secretary is required to examine the question of whether other health care professionals (e.g., physical therapists, occupational therapists, and speech-language pathologists) may be qualified to supervise patient care services provided by a home health agency. Further, the Secretary would be required to specify criteria and conditions for which they could fulfill the supervisory role. The report would be due April 1, 1986. The provision would be effective upon enactment.

Conference agreement

The conference agreement includes the Senate amendment with a modification that specifies the report is due to Congress prior to October 1, 1986.

29. Extension of working aged provisions to individuals over 69

Present law

The Age Discrimination in Employment Act (ADEA) requires employers of 20 or more people to offer employees and their spouses age 65-69 the same health insurance coverage they offer to younger employees and under the same conditions.

If the older employee chooses the employer's plan, medicare becomes the secondary payor if the employer plan does not pay full benefits.

If the older employer chooses not to participate in the employer's plan, medicare will be the primary payor. The employer is prohibited from offering a health plan designed to supplement medicare (i.e. fill in medicare's deductible and coinsurance).

Currently, ADEA applies only to persons between the ages of 40 and 70.

House bill

The House bill would extend the health insurance requirements of ADEA to persons over the age of 69, thereby removing the upper age limit, and makes corresponding changes in medicare law.

The House bill would amend ADEA to provide that the group health insurance requirement be exempted from the age limits.

The House bill would make other conforming amendments regarding special enrollment periods and the effective date of enrollment.

The House bill generally would be effective January 1, 1986 with certain exceptions.

Senate amendment

Similar provision.

Conference agreement

The conference agreement includes the Senate amendment with a technical modification.

30. Health maintenance organizations and competitive medical plans

a. Financial responsibility for patients hospitalized on the effective date of an enrollment or disenrollment.

Present law

Under current law it is unclear who is responsible for payment when a medicare beneficiary is an inpatient of a hospital under the prospective payment system on the effective date of his/her TEFRA HMO/CMP enrollment. A similar problem exists for disenrollment. A TEFRA HMO/CMP is a health maintenance organization or competitive medical plan with a risk contract under Section 1876 of the Social Security Act, authorized under the Tax Equity and Fiscal Responsibility Act of 1982.

House bill

Enrollment—a TEFRA HMO/CMP is not financially responsible for reimbursing covered inpatient stays in a PPS hospital for inpatient stays beginning before the effective date of the beneficiary's enrollment in the TEFRA HMO/CMP. Medicare will reimburse for the inpatient stay, if otherwise covered, as if the beneficiary were not enrolled in a TEFRA HMO/CMP. The TEFRA HMO/CMP will be responsible for any other services covered under medicare (i.e., all services except the inpatient stay, such as physician services provided to the patient during the inpatient stay) and any additional or supplemental services which would otherwise be due an enrollee, effective with the date of his/her enrollment in the TEFRA HMO/CMP.

Disenrollment—if the enrollee is an inpatient in a PPS hospital on the effective date of his/her disenrollment from the TEFRA HMO/CMP, the TEFRA HMO/CMP will be responsible for reimbursing for the full inpatient stay. Medicare will not make a monthly capitation payment nor will it pay for the inpatient stay under the regular medicare program after the effective date of disenrollment. The TEFRA HMO/CMP is not responsible for any other covered medicare services, or any additional or supplemental services to the enrollee, beginning on the effective date of disenrollment. This provision would apply only if the enrollee is an inpa-

tient of a PPS hospital provided for or arranged by the TEFRA HMO/CMP, or if the services were emergency or urgently needed services. The provision is effective for enrollments and disenrollments effective on or after October 1, 1985.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification changing the effective date to enactment.

b. Disenrollment procedures

Present law

Present law specifies the effective date of disenrollment from a TEFRA HMO/CMP to be the first calendar month following a full calendar month after the request is made for termination.

House bill

Disenrollments would be effective with the first day of the first month following the month in which the disenrollment request was made. The provision would require that the beneficiary receive a copy of the disenrollment form and that materials be provided to the beneficiary explaining how long he/she must continue to use the HMO/CMP facilities in order to have the services covered. The House bill requires that information be provided to beneficiaries clearly delineating when they may begin to use the regular medicare benefit. The provision is effective for requests for termination of enrollment submitted on or after October 1, 1985.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with a modification changing the effective date to February 1, 1986.

c. Review of marketing material

Present law

There are no present law provisions relating to marketing materials.

House bill

The House bill would require all TEFRA HMO/CMPs to submit all brochures, application forms, and promotional and informational material to the Health Care Financing Administration (HCFA) for approval, at least 45 days before issuance. HCFA would be required to review all these materials. If the HMO did not hear from the HCFA within the 45-day period, the organization could assume approval. The provision would apply to material for distribution on or after November 15, 1985. This provision would not apply to material which has been distributed prior to November 15, 1985.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with two modifications. The effective date is changed to April 1, 1986 and the provision would not apply to materials distributed prior to April 1, 1986.

*d. Prompt publication of the AAPCC**Present law*

In order to establish the payment amounts to TEFRA HMO/CMPs the Secretary has developed a measure called the Average Adjusted Per Capita Cost (AAPCC). There are no current law requirements relating to the specific date of publication of the AAPCC.

House bill

The House bill would require the Secretary to publish the AAPCC no later than September 7 of each year. The provision would apply to determinations of per capita rates of payment for 1987 and subsequent years.

Senate amendment

The Senate amendment would require the Secretary to publish the AAPCC no later than 10 days after publication of the hospital prospective payment rates.

Conference agreement

The conference agreement includes the House bill.

*31. Evaluation of preadmission and pre-procedure certification programs**Present law*

Peer review organizations (PROs) have the general responsibility of reviewing the quality and utilization of inpatient hospital services provided to medicare beneficiaries. PROs have been directed specifically by the Secretary of the Department of Health and Human Services to reduce the rate of inappropriate admissions. As a method to accomplish this goal, all PROs do preadmission screening on some elective surgery. Four PROs are currently conducting 100% preadmission review of non-emergency surgery.

House bill

The House bill would require the Secretary of HHS to evaluate the efficacy of PRO programs with 100% preadmission elective surgery review compared with programs that include less comprehensive review.

The Secretary would be required to evaluate the feasibility of extending PRO pre-procedure certification activities to outpatient and ambulatory settings. The Secretary would also be required to

consider whether other organizations, including medicare carriers, could more effectively conduct such pre-procedure screening.

The Secretary would be required to submit a report to Congress by December 31, 1986.

Senate amendment

No provision.

Conference agreement

The Conference agreement does not include the House bill.

32. Prohibition of administrative merger of renal disease networks with other organizations

Present law

Present law required the Secretary to establish network organizations to assure effective and efficient administration of the end stage renal disease (ESRD) program. The network organizations are responsible for coordinating and evaluating ESRD Services provided within assigned geographic areas. Thirty-two network organizations have been established.

House bill

Under the House bill, the Secretary is prohibited from merging any renal disease network organization into a utilization and quality control peer review organization or any other entity without express statutory authorization.

Senate amendment

Similar provision.

Conference agreement

The conference agreement includes the Senate amendment with modifications. The Secretary is permitted to consolidate the network areas and organizations in order to achieve efficiencies in the administration and operation of these organizations, provided the number of network organizations is not reduced to less than fourteen.

33. Extension of certain medicare municipal health services demonstration projects

Present law

Current law permits waiver of certain medicare requirements when the Health Care Financing Administration enters demonstrations under its general demonstration authority.

House bill

Under the House bill, the Secretary would be required to extend for three additional years, the three municipal health services health maintenance organization demonstration projects (Milwaukee, San Jose and Cincinnati) currently authorized under medicare demonstration authority. These demonstrations were authorized under authority provided in the Social Security Amendments of

1967 and 1972. The provision would be effective upon the date of enactment.

Senate amendment

Similar provision, except it includes an additional project in Baltimore.

Conference agreement

The conference agreement includes the Senate amendment.

34. Technical corrections

Present law

Current medicare law contains an number of technical errors.

House bill

(a) The House bill would correct problems with the medicare special enrollment period and the premium penalty forgiveness for the working aged. The anomaly under which certain individuals who are working and covered by an employer group health plan receive only one special enrollment period and others receive more would be corrected.

(b) In addition, the House bill would clarify that an individual would be eligible for forgiveness of the medicare penalty for any period during which he or she was over 65 and covered by an employer group health plan.

The provision requiring a person to meet the eligibility requirements of part A, and to have filed for part A, would be repealed.

(c) The House bill would make certain corrections in spelling, language and indentation.

Paragraph (a) would apply to the first month that begins more than 90 days after the date of enactment with certain exceptions.

Paragraph (b) would apply to months beginning January 1983 as they effect premiums for months beginning with the first month that begins more than 30 days after the date of enactment.

Paragraph (c) generally would be effective as though they had been included in the public laws that they correct.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

35. Coverage of respiratory care services for ventilator-dependent individuals

Present law

Medicare provides limited outpatient and home services to ventilator dependent individuals.

In order to qualify for home health services, a medicare beneficiary must be confined to his or her home and under the care of a physician. In addition, the person must be in need of part time or intermittent skilled nursing care or physical or speech therapy.

Once an individual qualifies for medicare's home health benefit, the beneficiary becomes entitled to a range of home health services.

In order to qualify for medicare's skilled nursing facility benefit, individuals must first be hospitalized for at least three consecutive days. They must also need skilled nursing or other skilled rehabilitation services on a daily basis for treatment related to the condition for which the beneficiary was hospitalized. Medicare law specifies the range of services which are covered in the skilled nursing facility.

House bill

No provision.

Senate amendment

The provision would amend medicare law to allow qualified respiratory care patients to qualify for medicare's home health and skilled nursing facility benefits and would include among covered services respiratory care for such individuals. The provision defines "qualified respiratory care patient" as an individual who has been hospitalized for at least 30 consecutive days, dependent on a respirator for life support at least 6 hours per day during that time, and is willing and medically able to be cared for in a less intensive setting.

The provision relating to medicare would be effective for services performed on or after October 1, 1988.

Conference agreement

The conference agreement does not include the Senate amendment.

36. Increase audit effort and medical claim review (sec.

Present law

Under current law, the Secretary contracts with intermediaries and carriers to perform the day-to-day administrative and operational tasks for the medicare program, including the review of claims and the conduct of audits.

House bill

No provision.

Senate amendment

The provision would require that medicare contractor budgets for fiscal years 1986, 1987, and 1988 be supplemented by \$105 million in each year to be spent specifically for provider cost audits and medical review activities. The provision would be effective October 1, 1985.

Conference agreement

The conference agreement includes the Senate amendment with a technical modification. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) earmarked \$45 million through FY85 for intensified review activities. This authorization is extended for three

years through FY88. The \$105 million under the Senate amendment represents an additional \$60 million above this amount.

The conferees intend that the Secretary has the flexibility to utilize the funding amounts in whatever manner the Secretary determines would be most cost-effective.

37. Charges by physicians for services billed to an HMO

Present law

Physicians who agree to become participating physicians, that is, accept assignment for all medicare patients, must accept medicare's reasonable charge determination as payment in full (subject to applicable cost-sharing) for services rendered to beneficiaries. When a participating physician provides an emergency service to a medicare beneficiary who is enrolled in a Health Maintenance Organization (HMO), the physician may bill the HMO. In this case, a participating physician does not have to accept assignment. Further a nonparticipating physician is not limited as to the amount he or she can charge the HMO (as he or she would otherwise be under the physician fee freeze provisions).

House bill

No provision.

Senate amendment

The provision would provide that participating and nonparticipating physicians cannot charge HMOs more for emergency services rendered to a medicare beneficiary than they could charge the beneficiary. The provision would be effective for items and services provided on or after October 1, 1985, and before October 1, 1986.

Conference agreement

The conference agreement does not include the Senate amendment.

38. Sense of the Senate with respect to coverage of liver transplant procedures for persons over 18 years of age under medicare

Present law

Section 1862 excludes from medicare coverage any items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. This section has been interpreted to exclude from coverage items and services that are considered to be experimental and that do not have a proven medical benefit. On February 9, 1984, the Secretary announced that liver transplants for persons under 18 years of age with certain specified conditions were no longer considered experimental and would, therefore, be covered under medicare.

House bill

No provision.

Senate amendment

The Senate amendment specifies the sense of the Senate, given available information regarding liver transplant services, that liver transplant services are to be covered under medicare and that the Secretary reconsider coverage of liver transplant services for individuals over 18 years of age.

Conference agreement

The conference agreement includes the Senate amendment with the understanding that the provision expresses only the sense of the Senate.

39. Extension of physician fee freeze for nonparticipating physicians and improvements in the participating physician program

a. Physician payments

Present law

Medicare pays for physicians' services on the basis of medicare-determined "reasonable charges". The reasonable charge for a service is the lowest of 1) a physician's billed charge; 2) the charge customarily made by the physician; or 3) the prevailing charge limit, derived from the charges made by all physicians in the geographic area for the service. The customary and prevailing charge screens are generally updated annually, on October 1. Increases in prevailing charge levels are limited by an economic index that reflects general inflation and changes in physicians' office practice costs.

Under the Deficit Reduction Act of 1984 (P.L. 98-369), the medicare customary and prevailing charges for all physicians' services provided during the 15-month period beginning July 1, 1984 were frozen at the levels that applied for the 12-month period ending June 30, 1984. The actual charges of nonparticipating physicians were also frozen during the 15-month period, at the levels in effect during April-June 1984.

The Deficit Reduction Act (DEFRA) also instituted a medicare participating physician and supplier program. Participating physicians and suppliers agree to accept assignment on all medicare claims for the 12-month period beginning on October 1 of a year. Nonparticipating physicians and suppliers can decide on a claim-by-claim basis whether or not to accept assignment.

The carriers responsible for paying medicare claims are required to monitor nonparticipating physicians' actual charges during the 15-month freeze. Physicians who knowingly and willfully bill beneficiaries in excess of what they charged during April-June 1984 can be subject to civil monetary penalties and/or exclusion from participation in medicare.

Public Law 99-107, Public Law 99-155 and Public Law 99-181 extended through December 18, 1985 the payment terms established in DEFRA. Physicians are bound during the extension period by the decisions they made regarding participation for the year beginning October 1, 1985, and are subject to the corresponding payment rules.

House bill

(Section 141)

Under the bill, an update in customary and prevailing charges would be provided on October 1, 1985 to all physicians who, as of that date, are participating physicians. The same prevailing charge screens would apply to all physicians who are participating as of that date, regardless of their prior participation status.

For any physician who is not covered by a participation agreement as of October 1, 1985, the current freeze on customary and prevailing charges would be extended through September 30, 1986. The current freeze on the actual charges of nonparticipating physicians would also be extended, for the same period. Formerly participating physicians who withdraw from the participation program for the year beginning October 1, 1985 would be required, like continuing nonparticipating physicians, to limit their actual charges to no more than the levels they charged during April-June 1984. The monitoring of nonparticipating physicians' actual charges would be continued through FY 1986.

On October 1, 1986, physicians covered by participation agreements effective for the year beginning October 1, 1986 would receive customary and prevailing charge updates. Nonparticipating physicians for the year beginning October 1, 1986 would also receive customary and prevailing charge updates. However, they would be subject to the prevailing charge limits applied to participating physicians during the prior participation period. This one-year differential would apply in future years, establishing a permanent gap between the prevailing charge screens to which participating and nonparticipating physicians are subject.

(Section 151)

The provision is identical to the one outlined for section 141, with the following exceptions:

Physicians who participated or took assignment on 100 percent of medicare claims during the year beginning October 1, 1984, but who are not participating as of October 1, 1985, would receive increases in their customary and prevailing charges on October 1, 1985, equal to one-half the increases they would have received had they been participating as of that date.

In addition, previously participating physicians who are not participating as of October 1, 1985 would be allowed to increase their actual charges by one-half the percentage increase in their actual charges during the July 1, 1984-September 30, 1985 period over their charges during the period April 1, 1984-June 30, 1984. These physicians' actual charges would then be monitored against these new levels. Charges in excess of the new freeze levels would not be recognized in computing customary charge updates on October 1, 1986.

Beginning October 1, 1986, the prevailing charge screens of physicians who participated or always accepted assignment in the immediately preceding year, but who do not participate in the current year, would lag behind those of participating physicians by

one-half the amount that other nonparticipating physicians' prevailing charges lag.

Senate amendment

The Senate amendment is similar to section 141 of the House bill with the following modifications. Physicians who were participating in fiscal year 1985, but who withdrew from the participating program in fiscal year 1986 would have their actual charges during the 12-month period ending March 31, 1985 reflected in the calculation of their customary charges for fiscal year 1986.

The Senate amendment would afford all physicians a second opportunity to exercise their option to enter into or terminate participation agreements for fiscal year 1986, during a 30-day period following enactment.

Conference agreement

The conference agreement includes the Senate amendment with a modification as follows.

The payment rates now in effect will be extended from December 19, 1985 through January 31, 1986. The freeze on nonparticipating physicians' actual charges to beneficiaries, and the monitoring of these charges, will also be extended during this period.

During the month of January 1986, physicians will have the opportunity to decide whether or not to participate for the 11-month period beginning February 1, 1986. New participation agreements can be signed or old ones terminated during January. In order to make existing participation agreements (which apply on a fiscal year basis) consistent with the new update and participation cycles (which will be on a calendar year basis), and in order to expedite implementation of the fee screen update for participating physicians, the agreement provides that existing participation agreements will be deemed to be in effect through December 31, 1986, unless terminated by the physician during January 1986. Therefore, physicians covered by agreements effective through September 30, 1986 who, during the month of January 1986, elect to continue participation do not have to sign new agreements; and the automatic renewal clause in the existing agreements will apply on a calendar year basis. Those physicians covered by participation agreements who wish to withdraw from participation for the 11-month period beginning February 1, 1986 must notify the carrier in writing during the month of January of their wish to do so.

On February 1, 1986, physicians who are covered by participation agreements on that date will receive customary and prevailing charge updates. The prevailing charges will reflect the updated customary charges of all physicians. With respect to most nonparticipating physicians, customaries will be updated solely for the purpose of updating participating physicians' prevailing charges. However, updated customaries will be used for payment purposes for nonparticipating physicians for the 11-month period beginning February 1, 1986 if they participated during fiscal year 1985.

For physicians who are neither participating on February 1, 1986 nor were participating during fiscal year 1985, the existing freeze on customary and prevailing charges will be extended through De-

ember 31, 1986. In addition, the freeze on actual charges (at April-June 1984 base period levels) will be extended through December 31, 1986 for all nonparticipating physicians, including those who were participating during fiscal year 1985. Monitoring of these physicians' actual charges continues for the same period.

The customary and prevailing charge screens applied on February 1, 1986 for participating physicians will be those that would have been applied for the October 1, 1985 update, had they not been frozen at the levels in effect on September 30, 1985. These October 1, 1985 charge screens reflect physicians' actual charges made during the 12-month period ending March 31, 1985. Use of these screens, rather than new ones based on a more recent period of charges (July 1, 1984 through June 30, 1985), will enable the carriers to apply the payment increases to participating physicians as expeditiously as possible. Construction and application of new screens would result in delaying the update significantly.

In order to compensate participating physicians for the prevailing charge increases that they will lose during the 4-month period beginning October 1, 1985 due to the freeze, the medicare economic index (MEI) applied to prevailing charges for services provided during the 11-month period beginning February 1, 1986, will be increased by one percentage point, approximately one-third of the total MEI increase due these physicians over the 12-month period beginning October 1, 1985. This one percentage point increase is a one-time increase to be applied only during the 11-month period, and is not built into the prevailing charge levels on a permanent basis. It is to be excluded in determining nonparticipating physicians' prevailing charges for the year beginning January 1, 1987.

Beginning January 1, 1987, participation agreements will be effective on a calendar year basis. Similarly, future customary and prevailing charge updates will be moved permanently from October 1 to January 1. Following February 1, 1986, the next participation period will begin and the next payment update will occur on January 1, 1987 and on each January 1 thereafter. The data base used to calculate the fee screens will also be moved forward by one quarter, to the period July 1 through June 30; thus, updates will continue to reflect physicians' actual charges made during the 12-month period ending six months prior to the update.

During the 45-day period (November 15 through December 31) immediately preceding a new participation period, physicians will have the opportunity to enter into participation agreements effective for the year beginning January 1, or to withdraw from existing agreements.

On January 1, 1987, and on each January 1 thereafter, physicians who are participating on that date will receive customary and prevailing charge updates, based on actual charges made during the preceding July 1 through June 30. Nonparticipating physicians will also receive customary charge updates, based on their actual charges made during that period.

For purposes of the January 1, 1987 customary charge update, actual charges exceeding the April-June 1984 base period levels, billed from October 1, 1985 through January 31, 1986 by a physician who was not participating during that four-month period, will not be recognized. Likewise, for purposes of the January 1, 1987

and January 1, 1988 customary charge updates, actual charges in excess of the April-June 1984 base period levels, billed from October 1, 1985 through December 31, 1986 by a physician who was not participating at the time of providing the service, will not be recognized.

For the year beginning on January 1, 1987, physicians who elect not to participate will be subject to the prevailing charges that were applied to participating physicians during the preceding participation period, excluding the temporary one percentage point increase in the MEI. For years beginning on January 1, 1988, and each January 1 thereafter, physicians who elect not to participate will be subject to the prevailing charges that were applied to participating physicians during the preceding participation period. This permanent one-year lag or differential in prevailing charges is intended to provide an incentive to physicians to participate, and reflects the priority the conferees attach to increasing participation.

b. Transfer of funds for carriers

Present law

The Deficit Reduction Act of 1984 provided for transfer from the Federal Supplementary Medical Insurance Trust Fund to carriers of at least \$8 million in fiscal year 1984 and \$15 million in fiscal year 1985 to implement the freeze and participating physician and supplier program.

House bill

The bill would extend for one year (FY 1986) the current law provision for the transfer of \$15 million from the Federal Supplementary Medical Insurance trust fund. The bill would require that a significant proportion of those funds be used for the expansion of the participation program and for the development of professional relations staffs dedicated exclusively to addressing the billing and other problems of participating physicians and suppliers.

Senate amendment

Identical provision.

Conference agreement

The Conference agreement includes the House provision with a modification as follows.

In addition to the \$15 million provided for in the House and Senate bills, a further \$3 million (total \$18 million) will be transferred from the part B trust fund to the carriers in fiscal year 1986, and will be available for obligation through December 31, 1986. These funds are intended to cover the costs of additional mailings by the carriers to physicians and suppliers explaining the changes in the fee freeze and participation program, and to cover the carriers' costs of implementing the fee freeze and participation program during the last three months of 1986.

The conferees intend that the Secretary devote sufficient funds to the carriers for maintenance of their toll-free telephone lines so that they are useful to beneficiaries seeking information about par-

ticipating physicians and suppliers. Sufficient resources should also be devoted to ensure that participating physicians and suppliers enjoy the benefit of the carriers' direct lines for the electronic receipt of claims.

c. Participating physician directory

Present law

DEFRA required the Secretary to publish annually a directory identifying participating physicians by name, address, and specialty. The directory is to be organized to make the most useful presentation of information.

House bill

The Secretary would be required to publish participating physician and supplier directories (rather than a single directory) for appropriate local geographic areas, and to provide for their distribution to each participating physician located in each such area.

Senate amendment

Identical provision.

Conference agreement

The Conference agreement includes the House provision. The conferees note that the directories of participating physicians and suppliers should be organized so as to be meaningful and useful to beneficiaries. For example, if, in especially large metropolitan areas, local medical markets can be identified, these should serve as the basis of organizing the directories. The requirement that the directories be sent to all participating physicians in an area is intended to facilitate and encourage the development of referral networks among participating physicians and suppliers.

d. Physician assignment rate list (PARL)

Present law

DEFRA required the Secretary to publish annually a list of physicians and suppliers serving medicare beneficiaries. The list is to include, for each physician and supplier name, address, specialty, and percent of claims accepted on assignment during the preceding year.

House bill

The House bill eliminates the requirement for the PARL directory.

Senate amendment

Identical provision.

Conference agreement

The Conference agreement includes the House provision.

*e. Explanation to benefits**Present law*

Medicare carriers inform beneficiaries of actions taken on their claims through Explanation of Medicare Benefits (EOMB) notices.

House bill

The bill would require that, for all unassigned claims, the Explanation of Medicare Benefits (EOMB) include a reminder to beneficiaries of the participating physician and supplier program, and provide them with the toll-free number for information in their area. The message would also remind beneficiaries of the limitation on the charges that participating physicians and suppliers may impose.

Senate amendment

Identical provision.

Conference agreement

The Conference agreement includes the House provision with the deadline moved to July 1, 1986. The conferees note that this provides the Secretary with ample time to pilot-test messages, if necessary, to ensure that they convey information to beneficiaries in a meaningful and appropriate fashion.

*f. Inapplicability of penalties**Present law*

No provision.

House bill

No provision.

Senate amendment

The Senate amendment would provide that the freeze imposed on actual charges to beneficiaries would not apply in cases where a claim for payment is not filed because the patient chooses to pay the entire bill from private sources.

Conference agreement

The Conference agreement does not include the Senate amendment.

*40. Physician payment assessment group and development of relative value scales**Present law*

There currently exists no advisory body whose purpose it is to make recommendations regarding medicare physician payment.

House bill

(Section 142)

The Director of the Congressional Office of Technology Assessment would appoint to the Prospective Payment Assessment Commission (ProPAC) two additional members to provide representation for rural hospitals and four nurses. In addition, the Director would appoint six new members to comprise a physician payment unit, which would function as a subcommittee of ProPAC.

The mission and ongoing duties of the physician payment subcommittee would be to make recommendations regarding medicare physician payment. Recommendations would address, among other issues, adjustments to reasonable charge levels for physicians' services, and changes in the medicare physician payment mechanism. The physician payment subcommittee would advise the Secretary on the development of a fee schedule based on a relative value scale (RVS), to be implemented by October 1, 1987.

(Section 152)

The section would provide for establishment of a physician payment review commission of 11 members, separate from and independent of ProPAC. The duties and activities of the commission are largely identical to those of the physician payment subcommittee of ProPAC outlined in section 142.

Senate amendment

No provision.

Conference agreement

The conference agreement includes section 152 of the House bill with a modification to conform the required functions to those specified in section 142 of the House bill.

*41. Part B premium**Present law*

The Secretary is required to calculate and announce each September the amount of the monthly premium that will be charged in the following calendar year for people enrolled in the Supplementary Medical Insurance (part B) portion of medicare. A temporary provision of law requires that for 1986 and 1987 the premium amount be calculated so as to produce premium income equal to 25 percent of program costs for enrollees age 65 and over.

Beginning in 1988, the premium calculation would revert to an earlier method under which the premium amount is the lower of: (1) an amount sufficient to cover one-half of program costs for the aged; or (2) the current premium amount increased by the percentage by which cash benefits were most recently increased under the cost-of-living adjustment (COLA) provisions of the social security program.

House bill

The House bill would extend for one additional year the existing temporary provision whereby the portion of part B costs financed by enrollee premiums equals 25 percent of program costs. If there is no social security cost-of-living adjustment, the monthly premium would not be increased that year.

Senate amendment

Same provision.

Conference agreement

The conference agreement includes the Senate amendment with a technical modification. There is no intent to change any policy other than to extend the date to 1988.

42. Inherent reasonableness determinations and customary charges for certain former hospital-compensated physicians

a. Inherent reasonableness

Present law

Payment for items and services under part B is generally made on the basis of reasonable charges. The law provides for some flexibility in the determination of reasonable charges; the regulations at 42 CFR 405.502(a)(7) allow the use of "other factors that may be found necessary and appropriate with respect to a specific item or service . . . in judging whether the charge is inherently reasonable."

House bill

The bill would require the Secretary to promulgate regulations which specify explicitly the criteria of "inherent reasonableness." The Secretary would be required to correct both excessive and deficient charges in accordance with these regulations.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

b. Hospital-compensated physicians

Present law

Carriers established compensation-related customary charges (CRCCs) for certain hospital-based physicians when combined-billing arrangements were eliminated, effective October 1, 1983. The CRCC provision was intended to be transitional; hospital-based physicians would have received customary charge updates on July 1, 1984 based on their actual charges had it not been for the general freeze on medicare customary and prevailing charges for physicians' services instituted by the Deficit Reduction Act.

House bill

In FY 1986, participating hospital-based physicians (HBPs) whose compensation-related charges were frozen as part of the general medicare fee freeze would, like other participating physicians, receive increases in their medicare payment based on their actual charges. Participating HBPs would receive increases that reflect charges that they made during the same base period used to update other participating physicians' charges (April 1984-March 1985). Nonparticipating HBPs would receive payments that reflect their charges during April 1984-March 1985, but deflated to approximate 1982 charges. This is the same period on which other nonparticipating physicians' payment is based.

Senate amendment

The Senate amendment would provide for the recalculation of the compensated-related customary charges (CRCCs). For services rendered between October 1, 1985, and September 30, 1986, the customary charges of physicians would be determined based on the physicians' actual charges made between April 1, 1984 and March 31, 1985. If such physicians had insufficient billings during that 12-month period, the calculation would be based on the first 3-month period beginning on or after February 1, 1985 for which sufficient billings are available. In either case, in order to put these physicians in the same position as other physicians, the actual charges will be deflated to September 1, 1984 levels in the case of physicians who were participating physicians during fiscal year 1985 or 1986; or to July 1982 in the case of physicians who did not participate in either year. The provision would be effective for services rendered on or after October 1, 1985, and before October 1, 1986.

Conference agreement

The conference agreement includes the House bill with a modification as follows.

Hospital-compensated physicians who, between October 31, 1982 and January 31, 1985 were in (and within the same period terminated arrangements by which they were compensated by a hospital for part B services furnished to its patients, will have customary charges calculated based on their actual charges. On February 1, 1986, physicians covered by this provision who are participating on that date will have their customary charges updated based on their actual charges billed during the 12-month period ending March 31, 1985. Physicians who are not participating on February 1, 1986 but who participated during fiscal year 1985 will have their customary charges updated in the same fashion. Physicians who were nonparticipating in fiscal year 1985 and who are not participating on February 1, 1986 will have their customary charges updated, and then deflated by .85 to approximate 1982 charge levels, on which other continuing nonparticipating physicians' customary charges are based.

Physicians who come off compensation arrangements between February 1, 1985 and December 31, 1986 will be treated as new physicians for purposes of establishing their customary charges. However, if a group or other entity continues to bill for or on

behalf of a physician who came off a compensation arrangement before January 31, 1985, the customary charges (as well as the actual charges, in the case of a nonparticipating physician) of the group or the entity billing for or on behalf of the physician would be imputed to the physician.

43. Occupational therapy services

Present law

Medically necessary occupational therapy services are covered under part A of medicare when provided as a part of covered inpatient or post-hospital extended care services in a skilled nursing facility, or as part of home health services or hospice care.

Part B coverage of occupational therapy services is limited to treatment in a hospital outpatient department, comprehensive outpatient rehabilitation facility, home health agency or when incident to a physician's service.

House bill

The House bill would extend reimbursement under part B of medicare for occupational therapy services. This therapy would be covered when provided in a skilled nursing facility (when part A coverage is exhausted), in a clinic, or a rehabilitation agency. Payment would be made on a reasonable cost basis.

The House bill would provide part B coverage of occupational therapy services when furnished in a therapist's office or a beneficiary's home. The independently practicing therapist would have to meet licensing and other standards prescribed by the Secretary. No more than \$500 in incurred expenses would be eligible for coverage in a calendar year per beneficiary. Payment would be based on 80 percent of reasonable charges.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill.

The conferees believe that the value of occupational therapy services to beneficiaries merits a modest expansion of the program. Further, the conferees find that such services have the potential to reduce and avoid the need for institutional care while enabling the beneficiary to function more independently.

44. Payment for durable medical equipment and other nonphysician services

Present law

Payment for durable medical equipment (DME) is paid under part B on the basis of reasonable charges. In the past, payment for DME was made for both rented and purchased items, depending on the beneficiary's decision to either rent or purchase. As a result, the majority of DME was rented, even when purchase would have been more economical.

Beginning February 1, 1985, the Secretary implemented three methods for reimbursing DME under medicare: lease-purchase, lump sum purchase or rental charges. Equipment costing less than \$120 is considered inexpensive equipment and payment is made only on the basis of purchase. For equipment costing more than \$120, the carrier must determine which method is cost-effective based on the beneficiary's expected need for the equipment (as indicated on the physician's prescription) and reimburse accordingly. Used equipment that is purchased and that meets certain standards is reimbursed at 100 percent rather than 80 percent of the reasonable charges (applicable copayment amounts are waived).

House bill

(Section 146)

a. Fiscal year 1986 payment level

The House bill would set new reimbursement limits on rented durable medical equipment (DME). In determining medicare's customary and prevailing charges for rented DME during FY 1986, the Secretary would allow an increase of no more than one percent over the level set for rented DME furnished beginning July 1, 1984.

b. Mandatory assignment

The House bill would provide that payment for DME provided on a rental basis would only be made on the basis of assignment.

c. Limits on annual increase in prevailing charges

For DME items furnished during fiscal years beginning on or after October 1, 1986 the House bill would limit the annual percentage increase in prevailing charges for rental and purchase to no more than the increase in the Consumer Price Index for all urban consumers for the 12-month period ending the preceding March.

d. Clarification of DEFRA effective date

The bill clarifies that the DEFRA provision moving updates of customary and prevailing charges to October 1 also applies to DME.

Effective Date

Paragraph (a) would be effective with respect to items or services furnished on or after October 1, 1985.

Paragraph (b) would be effective with respect to supplies or items furnished on or after January 1, 1986.

Paragraph (c) would be effective with respect to items or supplies furnished on or after October 1, 1986.

Paragraph (d) effective as though included in DEFRA.

(Section 153)

a. Fiscal year 1986 payment level

This section is similar except that it would freeze both customary and prevailing charges for rented DME and for purchases of oxygen supplies during FY 1986 at the same level for supplies furnished during the 15-month period beginning July 1, 1984.

b. Mandatory assignment

This section is similar except that payment for purchases of oxygen supplies, in addition to DME provided on a rental basis, would only be made on the basis of assignment.

c. Limits on annual increase in prevailing

This section is similar except that future increases in payment for purchases of oxygen supplies, in addition to DME provided on a rental basis, would be limited to the CPI.

d. Clarification of DEFRA effective date

Same provision.

Same effective dates.

*Senate amendment**a. Fiscal year 1986 payment level*

The provision would impose new reimbursement limits on non-physician services paid on a reasonable charge basis under part B other than DME that is lump-sum purchased or furnished under a lease-purchase agreement and independent clinical laboratory services. During fiscal year 1986, medicare customary and prevailing charges for services subject to the limits would be allowed to increase by 1 percent over the level in effect for the 15-month period beginning July 1, 1984.

b. Mandatory assignment

No provision.

c. Limit on annual increase in prevailing

For items and services furnished in fiscal year 1987 and thereafter, medicare prevailing charges could rise no faster than the increase in the Consumer Price Index. The provision would be effective October 1, 1985.

Conference agreement

The conference agreement includes section 153 of the House bill with modifications. Customary and prevailing charges and lowest charge levels will be frozen for the period October 1, 1985 through January 31, 1986 for nonphysician and nonlaboratory supplies and services. This means that medicare fee screens for all nonphysician services paid for on a reasonable charge basis under Part B are

frozen at the level which was in effect for such services for the 15-month period beginning July 1, 1984.

The agreement provides that the freeze is extended for the eleven-month period February 1, 1986–December 31, 1986 for rented durable medical equipment and consumable oxygen. Beginning April 1, 1986, and thereafter, payment for those items and services would be made only on the basis of assignment; that is, suppliers would have to accept the medicare reasonable charge as payment in full (except for the deductible and copayment).

The agreement specifically precludes extension of the freeze after February 1, 1986 for purchased DME and other nonphysician services paid for on a reasonable charge basis. Thus, other nonphysician suppliers and services would receive the full update in customary and prevailing charge screens for the 11-month period beginning February 1, 1986. This is the update that would have been effective on October 1, 1985, but for regulations issued by the Secretary which froze the rates.

Future updates of customary, prevailing, and lowest charge level screens for DME and other nonphysician services will occur on January 1 of each year beginning in 1987. Beginning January 1, 1987, the annual increase in the prevailing charge screens for rented DME and consumable oxygen will be limited to the increase in the Consumer Price Index for all urban consumers (U.S. city average). Beginning January 1, 1988, the annual increase in the prevailing charge screens for purchased DME will be subject to the same limit. For the purpose of this section, purchased DME includes DME furnished on a lease-purchase basis.

The base period for calculation of customary and prevailing charge screens is the 12-month period ending the preceding June 30. The base period for the lowest charge levels is the three-month period ending the preceding September 30.

The conference agreement for the DEFRA effective date provision includes the House provision, with a modification to specify that the provision applies for all, rather than some, part B nonphysician services except lab tests.

45. Payment for assistants at surgery for certain cataract operations and other operations

Present law

Currently, medicare covers assistants at surgery during routine cataract operations. Their services are considered reasonable and necessary if it is generally accepted practice among ophthalmologists in the local community to use an assistant at surgery. Some medicare carriers restrict coverage of assistants at surgery to cases where medical necessity is established.

House bill

The House bill would deny medicare payment for assistants at surgery for routine cataract operations. In cases where complicating medical conditions exist, the Secretary would be required to establish procedures by which the primary surgeon could request prior approval from the PRO for the use of an assistant.

The House bill would prohibit the assistant at surgery (or someone on his or her behalf) from billing medicare or the beneficiary for services which did not receive prior approval. In addition, the primary surgeon (or someone on his or her behalf) would be prohibited from including charges for the assistant in his or her bill if prior approval had not been received. In order to enforce this provision, the House bill would provide the Secretary authority to impose civil monetary penalties or assessments, or exclusion for up to five years from the medicare program.

The House bill would require the Secretary, after consultation with the physician payment review group, as constituted under section 142 or 152 the House bill, to develop and report to Congress by April 1, 1986, recommendations and guidelines regarding other surgical procedures for which an assistant at surgery generally is not medically necessary. The Secretary would be required to include in this report procedures by which the primary surgeon could request prior approval from an appropriate entity for the use of an assistant at surgery when prior approval is required for those surgical procedures.

The House bill would be effective with respect to services performed on or after October 1, 1985.

Senate amendment

Similar provision.

Conference agreement

The conference agreement includes the Senate amendment with a modification to allow the Secretary discretion to require the carrier or PRO to be the entity from which the primary surgeon requests prior approval for the use of an assistant at surgery. It is the intent of the conferees that this modification would facilitate timely implementation of the provision.

The conferees reviewed the findings of the Office of the Inspector General, HHS, which stated that the use of an assistant at surgery has not medically necessary in most situations. In addition, several medicare carriers currently restrict coverage of assistants at surgery, and there has been no indication that this has an adverse effect on patients.

The agreement further specifies that the provision applies to services performed on or after April 1, 1986. The Secretary's report to Congress on the recommendations and guidelines is due no later than January 1, 1987.

46. Limitation on medicare payment for post-cataract surgery patients (sec. 148)

Present law

Medicare part B pays for certain combinations of prosthetic lenses for post-cataract surgery patients, if determined to be medically necessary by the physician, i.e. cataract contact lenses and eyeglasses. Generally, part B carriers are authorized to replace prosthetic lenses without a physician's prescription in cases of loss or irreparable damage and when supported by a physician's prescription in cases of a change in the patient's condition. Currently,

there are not uniform limits on the number of replacements for which medicare will provide reimbursement.

Physicians can bill medicare for services related to cataract surgery in two ways: (1) a comprehensive service code covering the lenses, their fitting and evaluation, and short-term follow-up to assure their suitability; or (2) separate codes for the lenses and for the physician's service.

House bill

The House bill would limit medicare reimbursement with respect to replacement of lost or damaged prosthetic lenses as follows:

- (1) cataract eyeglasses; one replacement each year;
- (2) cataract contact lenses; one original and two replacements per eye the first year after surgery and two replacements per eye each subsequent year.

The House bill would require the Secretary to provide for separate payment amount determinations for the prosthetic lenses and for the related professional services, and to apply inherent reasonableness guidelines, in accordance with the bill, in determining the reasonableness for charges for prosthetic lenses.

The House bill would be effective for items or services furnished on or after October 1, 1985.

Senate amendment

Similar provision.

Conference agreement

The conference agreement includes the Senate amendment with respect to payment limitations with a modification specifying that the provision applies to items and services furnished on or after April 1, 1986. The conference agreement does not include the limitations on replacements of eyeglasses and contact lenses.

47. Demonstration of preventive health services under medicare

Present law

Medicare does not generally provide coverage of preventive health services.

House bill

The House bill would require the Secretary of HHS to fund at least five demonstrations, under the auspices of schools of public health, to determine whether and how it would be cost-effective to include preventive services as a medicare benefit.

The House bill would require that certain preventive health services be made available to medicare beneficiaries. Such services would include health screenings, health risk appraisals, immunizations, counseling and instruction on such matters as diet and nutrition, reduction of stress, exercise, sleep regulation, prevention of alcohol and drug abuse and mental health disorders, self-care and smoking reduction.

The Secretary would be required to submit a report to Congress describing the demonstrations in progress within three years. Within five years, the Secretary would be required to submit a

final report that would evaluate the costs and benefits of providing such services and recommend whether specific preventive services should be included as a medicare benefit.

The House bill would be effective October 1, 1985.

Senate amendment

Similar provision.

Conference agreement

The conference agreement includes the Senate amendment with a modification that specifies that the demonstrations be conducted under the auspices of schools of public health and medical schools with preventive medicine departments accredited by the Council on Education for Public Health. It is the intent of the conferees that at least one of the projects include cancer screening (including breast cancer screening).

48. Ambulatory surgery

Present law

Medicare may pay for ambulatory (i.e., outpatient) surgical procedures performed in three different settings.

(a) Ambulatory Surgical Center (ASC).—The “Omnibus reconciliation Act of 1980” authorized payments for surgical procedures, to be specified by the Secretary, performed in an ASC to be made on the basis of prospectively set rates. On August 5, 1982, the Department issued final regulations and an accompanying notice identifying four groups of surgical procedures and the payment amount for each group. The payment amounts and the list of procedures has not been updated.

The prospective payment rates do not include payments for physicians’ services, prosthetic devices, or laboratory services.

Under the 1980 legislation, the costs related to the use of an ASC were covered in full. The Congress waived the 20 percent copayment usually required of patients for such part B services in order to foster greater use of ambulatory surgical centers as opposed to higher cost hospitals.

(b) Hospital outpatient departments.—Medicare payments for ambulatory surgery performed in a hospital outpatient department are made on the basis of reasonable costs. As a part B service, a 20 percent copayment is required of the patient in connection with the costs related to the use of the facility.

(c) Physician’s office.—The “Omnibus Reconciliation Act of 1980” also authorized payments to be made to physicians for the use of their office facilities when covered ambulatory surgical procedures were performed there. However, the legislation has not been implemented because adequate utilization and quality control peer review, which is required by law, is not available for office-based surgery.

When surgery is performed in any of these three settings, medicare reimburses 100 percent of the physician’s reasonable charge, provided the physician agrees to accept assignment, otherwise the 20 percent copayment is imposed on the beneficiary.

House bill

No provision.

Senate amendment

The provision would extend the ASC prospective payment approach to hospital outpatient surgery for all procedures which the Secretary approves for the ASC; 150 are currently approved. The rates for ambulatory surgery in all settings would be increased to include the costs associated with a given procedure, including prosthetic devices and lab work. Professional fees would not be included. The provision specifies that the pass-through for direct graduate medical education and capital costs associated with the surgery that is now paid to hospitals would be continued. Further, separately calculated payments would be provided to take into account the costs of services provided by a Certified Registered Nurse Anesthetist (CRNA).

The Secretary would be required to update the present ASC prospective rates to reflect current costs. No rate could exceed the DRG payment rate for comparable inpatient surgery. The rates would be updated annually.

The provision would require the Secretary to have PROs review outpatient surgical procedures.

Finally, the provision would eliminate the current law provisions which waive copayments in connection with both the use of the facility and the physician's charge.

The provisions relating to the updating of payments and lists of procedures would be effective January 1, 1986. Payment amounts for ambulatory procedures that are furnished in ASCs and physicians' offices would be updated prior to January 1, 1986. Other provisions would be effective October 1, 1985.

Conference agreement

The conference agreement does not include the Senate amendment.

*49. Payment for clinical laboratory services**Present law*

Outpatient clinical diagnostic laboratory services are reimbursed according to fee schedules established by medicare carriers. The initial fee schedules, which went into effect on July 1, 1984, were established at a percentage of the prevailing charges that would have gone into effect on that date. The fee schedules are to be updated on July 1 of each year by the percentage change in the Consumer Price Index for all urban consumers (CPI-U).

The fee schedules are currently calculated and applied on the basis of a statewide or substate geographical area. Beginning July 1, 1987, a national fee schedule is to be established for tests performed in a physician's office, by a freestanding laboratory, or by a hospital (if the test is for a person who is not a patient of that hospital). The fee schedules are to expire July 1, 1987 for hospital laboratory tests performed for outpatients of the hospital; payment for these services would revert to cost-based reimbursement. Payment may only be made to the person or entity who performed such test.

Hospital laboratories and independent laboratories are subject to standards designed to protect the health and safety of patients and to monitoring of compliance with such standards. Laboratories located in physicians' offices are not subject to such standards or monitoring.

House bill

The House bill moves the timing of the annual update to October 1, beginning in 1986. The annual update which would take effect on October 1, 1986 would take into account the change in the CPI-U occurring over the preceding 15-month period. The expiration date for the fee schedules for tests done by hospital-based laboratories would be delayed 3 months, to October 1, 1987.

The Secretary of Health and Human Services would be required to establish a ceiling on the maximum amount medicare would pay under the current fee schedules. A different ceiling would be set for each test and would be applied nationwide. The ceiling would be set at 115 percent of the median fee for each procedure beginning on January 1, 1986, and at 110 percent of the median beginning on October 1, 1986.

The Secretary would also be required to report to Congress, within one year after the date of enactment, on standards which could be established to protect the health and safety of patients of clinical laboratories which are part of, or associated with, a physician's office. In recommending standards, the Secretary is to consider such factors as scope, type and complexity, which may indicate a need for different standards for laboratories with different characteristics.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with the following modifications. The annual update of the fee schedules will occur January 1 of each beginning in 1987. The annual update which will take effect on January 1, 1987 will take into account the change in the CPI-U occurring over the preceding 18-month period. The fee schedule for laboratory tests furnished by hospitals for outpatients is extended through December, 1987.

The conference agreement further modifies the House bill to specify that the ceilings would be set at 115 percent of the median fee for the respective tests beginning on April 1, 1986 and 110 percent of the median beginning on January 1, 1987. The national fee schedule for laboratory services would go into effect on January 1, 1988.

It is the conferees understanding that there may be a limited number of lab tests where there is some discrepancy in the service reported for the procedure code (such as organ or disease oriented panel tests). In these isolated cases, a reasonable delay in application of the limits on fee schedules may be appropriate.

The conference agreement further specifies that beginning January 1, 1987, medicare payments for laboratory services performed in a physician's office will only be made on the same basis as pay-

ments to independent clinical labs. Payment will be made only on the basis of assignment, and the patient's deductible and coinsurance will be waived.

The conferees continue to be concerned about the Secretary's lack of progress in simplifying the current billing requirements for laboratory services. Such simplification may include eliminating requirements that a patient diagnosis appear on a clinical laboratory bill, mechanisms to ensure prompt payment, minimizing the amount of information required for claims processing and facilitating bulk or periodic billing for multiple beneficiaries.

The conference agreement reinstates section 1123 of the statute regarding proficiency testing, through September 30, 1987.

50. Vision care

Present law

Medicare pays for eye examinations furnished by a physician to a patient with a complaint or symptom of eye disease or injury. Medicare does not pay for eyeglasses or for eye examinations for the purpose of prescribing, fitting, or changing eyeglasses (except for prosthetic lenses for aphakic patients; that is, those without the natural lens of the eye). Payment is also denied for procedures performed to determine the refractive state of the eye. An optometrist who is legally authorized by the State to practice optometry is defined as a physician, but only with respect to services related to the treatment of aphakic patients.

House bill

Payment would be made under medicare for vision care services performed by optometrists, if the services are among those already covered by medicare when furnished by a physician and if the optometrist is authorized by State law to provide the services.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House bill with an effective date of July 1, 1986. The conferees are concerned that many beneficiaries are either foregoing covered eye care or are paying out-of-pocket for eye care services furnished by optometrists, because they do not have ready access to an ophthalmologist. The bill would not expand or change the current coverage and reimbursement rules in any other manner. It is the conferees' expectation that the medicare carriers, with guidance from HCFA, would use information regarding payments they make for optometrists' services under their own health plans, or other appropriate information, to establish the initial customary and prevailing charge screens.

51. *Second opinions*

Present law

Medicare payment will be made for medical and other health services if the services are reasonable and necessary. Although a medicare beneficiary may seek a second opinion prior to undergoing surgery, a second opinion is not required as a precondition to payment.

Utilization and quality control peer review organizations (PROs) are authorized to determine whether services and items furnished in connection with medical care are reasonable and medically necessary. PROs conduct pre-admission reviews with respect to a limited number of elective surgical procedures, but are not authorized to require a second opinion as part of the pre-admission review process.

House bill

a. Mandatory second opinions

Payment for certain elective surgeries would be denied under both part A and part B, unless the patient obtained a second opinion from a qualified physician. Payment would not be denied if the second opinion did not agree with the first.

b. Required procedures

The Secretary of Health and Human Services would be required to designate at least ten surgical procedures for which second opinions would be required, chosen from those that can be postponed without undue risk, that are high volume or high cost procedures, and that have a high rate of nonconfirmation. The Secretary could vary the list for each geographic area if available data on volume and costs suggest that it would be cost-effective to do so. The Secretary would also be required to specify which type of specialist must be consulted for each of the listed procedures.

c. PRO functions

Utilization and quality control peer review organizations (PROs) would serve as referral centers to assist patients in obtaining second opinions. The PRO would maintain a list of qualified physicians and would tell the patient which physicians are participating physicians and which have agreed to accept assignment for second opinions. At the patient's request, the PRO would refer the patient to an appropriate physician for a second opinion. The patient could choose any physician of the proper specialty to provide the second opinion, as long as the physician was not affiliated with or did not have any common financial interest with the physician who rendered the first opinion. The Secretary could enter into an agreement with a State or local agency or appropriate private entity (other than a PRO) under certain circumstances.

d. Waiver of requirements

The requirement for a second opinion would be waived if (1) delay would pose a risk to the patient; (2) no physician is reasonably available who is (a) an appropriate specialist, and (b) a participating physician or a physician who has agreed to accept assignment for the second opinion; or (3) the patient is enrolled in a health maintenance organization or competitive medical plan with a medicare risk-sharing contract.

e. Beneficiary notification responsibilities

Physicians, hospitals, and ambulatory surgical centers would be obligated to inform patients about the requirement for a second opinion and would be subject to civil monetary penalties and exclusion from the program for failing to do so.

f. Secretarial notification requirements

The Secretary would be required to notify all physicians, hospitals with medicare agreements, and ambulatory surgical centers with medicare agreements, of these second opinion requirements, including the applicable list of surgical procedures and a description of the penalties for failure to notify a patient about the requirement for a second opinion.

The Secretary would also be required to provide periodic notice to medicare beneficiaries of the second opinion requirements, including the applicable list of the surgical procedures and information about the availability of the second opinion referral services.

g. Deductible and coinsurance waiver

The deductible and coinsurance would be waived for the second opinion (and for a third opinion, if the second was in disagreement from the first).

h. Conforming amendments

The bill makes conforming amendments regarding exclusions from coverage, provider agreements, and functions of PROs.

i. Contingency procedures list

If the Secretary did not establish a list or lists of surgical procedures requiring second opinions within six months after enactment, a statutory list of procedures would go into effect.

j. Study

The Secretary would be required to conduct a study of the results of the amendments made by this section. The study must include any changes in utilization of surgical procedures, changes in non-confirmation rates of second opinions, and outcomes in cases where surgery is not done after a second opinion failed to confirm the necessity of the surgical procedure.

The provision would become effective the first month which begins more than 6 months after enactment. The Secretary must

promulgate final regulations necessary to implement the amendments made by this section within six months after enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with modifications as follows.

a. Mandatory second opinions

PROs would be required to perform 100 percent pre-procedure review on at least 10 elective surgical procedures whether the procedure is performed on an inpatient or outpatient basis. Pre-procedure review would be required as a condition of payment except that review would be waived in the case of a medical emergency or under other circumstances as the Secretary may specify. PROs would be authorized to require a second opinion for these procedures as part of the pre-procedure review process if a second opinion is warranted to assist the beneficiary regarding the need for the procedure.

b. Required procedures

The procedures that would be subject to pre-procedure review by a PRO pursuant to this provision would be specified in a contract negotiated between the PRO and the Secretary. Existing contracts (which are on a 2-year cycle) will expire during 1986. New contracts will be signed between June and October 1986. Therefore, implementation of this provision will require renegotiation of signed contracts.

The Secretary would be required to develop guidelines for determining whether a surgical procedure is appropriate for inclusion in the pre-procedure review program. These guidelines would be based on three general requirements. First, the procedure must be one which generally can be postponed without undue risk to the patient. Second, the procedure must be sufficiently costly, or of sufficient volume, as to make it probable that savings to the medicare program would result from effective review. Third, there must be a basis for concluding that pre-procedure review of that procedure is likely to be cost-effective. Such a basis could appropriately include data regarding the frequency with which a second opinion results in a recommendation against surgery and data regarding small area (or regional) variations in the incidence of the procedure. The Secretary is expected to apply these criteria flexibly in developing an appropriate list of procedures.

The Secretary would also be required to develop a list of procedures appropriate for inclusion in the program. The list would include substantially more than ten procedures. PROs would not be bound to include only procedures listed by the Secretary. Subject to negotiation, a PRO could include other procedures when cost-effective and consistent with general criteria specified in the provision. A PRO could review different sets of procedures in various regions of its service area. It is expected that a PRO will identify proce-

dures for inclusion in this program based, in part, on information pertaining to patterns of medical practice within the PRO's service area.

Finally, the Secretary would be required to develop criteria specifying the type of specialist that must be consulted for each procedure, and the circumstances under which a physician may not provide a second opinion because of a common financial interest with the physician who rendered the first opinion.

c. PRO functions

A PRO could approve or disapprove a procedure as reasonable and necessary without requiring a second opinion. In addition, the PRO could require a second opinion and allow the beneficiary to decide among conflicting opinions. A second opinion should not be required if additional information could be obtained from the first physician which would resolve outstanding uncertainties as to medical necessity. Second opinions also should not be required in instances in which it is clear on the basis of available information that the procedure is not needed.

If the PRO requires a second opinion, the beneficiary generally would be free to choose any appropriately qualified physician. However, physicians with a possible conflict of interest, or physicians who have been disqualified by the PRO, would be prohibited from providing second opinions. A physician could be prohibited from providing second opinions if the PRO determines that the physician has rendered grossly unreliable second opinions.

The PRO would be required to assist the patient in identifying a qualified physician for a second opinion and would be required to forward medical records to the physician providing the second opinion. The PRO would not be required to transmit the records in a manner that would conceal the identity of the physician who rendered the first opinion.

d. Waiver of requirements

The conference agreement accepts the House provision regarding waiver of the requirement for a second opinion.

e. Beneficiary notification requirements

The detailed beneficiary notification requirements set forth under the House provision are replaced in the conference agreement by more general notice requirements. It is understood that general requirements with respect to beneficiary notification under the PRO program will apply to pre-procedure reviews under this section.

f. Secretarial notification requirements

Under the conference agreement, the Secretary would be required to arrange for appropriate notice to physicians, hospitals, ambulatory surgery centers, and beneficiaries regarding the pre-procedure review program.

g. Deductible and coinsurance waiver

The conference agreement accepts the House provision.

h. Conforming amendments

The conference agreement accepts the House provision.

i. Contingency procedures list

The conference agreement does not include the House provision.

j. Study

The conference agreement includes a study to be conducted by the Secretary. The study is to evaluate the results of the program on utilization of surgical procedures, changes in nonconfirmation rates and, where possible, outcomes. It is also to evaluate the appropriateness of the procedures actually selected for reviews and PRO patterns with respect to requiring second opinions. Finally, the study is to assess the effectiveness of reviews mandated under this section as compared with other methods of ensuring the medical necessity of surgical procedures. The study is due 36 months after enactment.

The conferees agreed that the effective date would be January 1, 1987.

*52. Changing medicare appeal rights**Present law*

Beneficiaries dissatisfied with a carrier's disposition of a part B claim are entitled to a review by the carrier. A fair hearing by the carrier is then available if the amount in controversy is \$100 more. The law does not provide for any further administrative appeal or judicial review for a part B claim.

Since the inception of the program, beneficiaries with disputes over claims could be represented by providers in their administrative appeals. In 1984, the Health Care Financing Administration issued a manual instruction prohibiting such representation.

House bill

The House bill provides that beneficiaries may obtain an administrative law judge hearing for part B claims if the amount in controversy is \$500 or more, and a judicial review if the amount in controversy is \$1,000 or more. In determining the amount in controversy, the Secretary, under regulations, must allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals. The current carrier hearing would be retained for amounts in controversy between \$100 and \$500.

The bill also clarifies that beneficiaries taking appeals under part A or part B could be represented by the provider who furnished the services or items in question.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with a modification to specify that a national coverage determination made pursuant to section 1862(a)(1)(A) of the Act may not be reversed upon appeal. These determinations are made by the Health Care Financing Administration (HCFA), generally after consultation with the National Center for Health Service Research and Health Care Technology Assessment, and are contained in the Coverage Issues Appendix (now called Medicare Coverage Issues Manual) to the intermediary and carrier manuals.

With the additional workload that would be established under the bill, it is the conferees' expectation that HHS will give serious consideration to establishing a separate office of hearings and appeals for HCFA or otherwise creating a group of hearing officers devoted exclusively or predominately to medicare appeals.

*53. Extension of On Lok waiver**Present law*

The On Lok Community Care Organization for Dependent Adults provides health care services to frail elderly patients at risk of institutionalization. On Lok conducted a demonstration project from February 1979 to October 1983, with the aid of waivers of compliance with certain medicare and medicaid requirements. P.L. 98-21 required the Secretary to approve waivers for a new three-year, risk-sharing, capitated payment demonstration to be conducted by On Lok from November 1983 to November 1986.

House bill

The Secretary would be required to extend medicare waivers for the risk-sharing On Lok demonstration upon their expiration and, if the State of California applies for an extension of related medicaid waivers, to approve the State's application. The waivers would be extended on the same terms and conditions as applied to the original approval mandated under P.L. 98-21 (except that requirements for collection and evaluation of information for demonstration purposes should not apply) and would remain in effect until the Secretary found that the applicant no longer complied with those terms and conditions. The provision would be effective upon enactment.

Senate amendment

Similar provision.

Conference agreement

The conference agreement includes the House bill.

54. *Remove restriction on actuarial opinion*

Present law

Annual reports required of the Board of Trustees on the financial status of the Social Security trust funds (including the medicare trust funds) must include an actuarial opinion certifying that the assumptions and cost estimates used in the report are reasonable. According to provisions in the Social Security Amendments of 1983 (P.L. 98-21), this certification may not refer to the economic assumptions underlying the trustees report.

House bill

No provision.

Senate amendment

The provision would allow the actuaries to comment on the economic assumptions underlying the trustee's report. It would be effective upon enactment.

Conference agreement

The conference agreement includes the Senate amendment.

55. *Extend GAO reporting date*

Present law

The Deficit Reduction Act of 1984 (DEFRA) required the General Accounting Office (GAO) to study the following aspects of medicare contracting for claims processing:

The ability of HCFA to manage competitive bidding and the relative costs of competitive arrangements compared with cost based reimbursement;

The appropriateness of removing the provider nomination requirements in the statute;

Any disparities in costs and quality of claims processing among various intermediaries and carriers;

Whether the Secretary's standards for evaluating contractor costs are adequate and properly applied; and

Whether the Secretary's authority is sufficient to deal with inefficient intermediaries and carriers either through the contract negotiation and budget review process or through the process of termination or nonrenewal of contracts.

DEFRA required submission of the report to Congress within 12 months of enactment, i.e., by July 18, 1985.

House bill

No provision.

Senate amendment

The provision would extend the reporting date to 18 months after the enactment of DEFRA (i.e. January 18, 1986) to allow the GAO to expand the scope of the study as requested by the committees of jurisdiction (i.e. Senate Committee on Finance, House Committee on Ways and Means, and House Committee on Energy and Commerce).

The provision would be effective as if originally included in the Deficit Reduction Act of 1984.

Conference agreement

The conference agreement includes the Senate amendment with a modification specifying that the GAO report is due May 1, 1986.

56. Allow greater HMO membership on PRO boards

Present law

The Secretary must enter into contracts with organizations to provide utilization and quality control peer review of the health care services paid for under medicare. The contractors are referred to as Peer Review Organizations (PROs). An applicant whose governing body has more than one member who is affiliated with a health maintenance organization (HMO) is given secondary preference to physician-sponsored or physician-assisted entities when PRO contracts are awarded.

House bill

No provision.

Senate amendment

The provision would allow PROs with more than one HMO board member to qualify as a PRO on the same basis as other organizations. The provision would be effective upon enactment.

Conference agreement

The conference agreement includes the Senate amendment.

57. Peer Review Organization Reimbursement

Present law

Section 1866(a)(1)(F)(iii) of the Social Security Act specifies that Peer Review Organization reimbursement is to be set at a level which reflects peer review rates established in fiscal year 1982 for both direct and administrative costs (adjusted for inflation). Section 1866(a)(1)(F)(iv) specifies that the aggregate reimbursement for a fiscal year may not be less than the aggregate amount expended in fiscal year 1982 (adjusted for inflation).

House bill

No provision.

Senate amendment

The provision deletes section 1866(a)(1)(F)(iii) and substitutes fiscal year 1985 for fiscal year 1982 in clause (iv). Reimbursement shall be made to the organization on a monthly basis, with payments for any month being made not later than 15 days after the close of such month. This change is to address the concern that current law provisions could be used to restrict PRO reimbursement. The provision would be effective on enactment.

Conference agreement

The conference agreement includes the Senate amendment with a modification specifying that fiscal year 1986 is the base year against which aggregate expenditures are compared.

*58. PRO review of Health Maintenance Organization Services**Present law*

Current law requires the Secretary of Health and Human Services to contract with Peer Review Organizations (PROs) for the review of the medical necessity, quality, and appropriateness of services provided to medicare beneficiaries. The PROs are required to review some or all of the professional services provided under medicare. Each PRO, in consultation with the Secretary, determines the types and kinds of cases over which it will exercise its review authority in order to most effectively meet its responsibilities.

On January 10, 1985, the Secretary published final regulations to implement the 1982 TEFRA health maintenance organizations (HMOs) and competitive medical plans (CMPs) contract provisions with medicare. The final regulation includes a provision that requires HMOs and CMPs with contracts under section 1876 to comply with the requirement for PRO review of services furnished to medicare enrollees.

House bill

No provision.

Senate amendment

The provision would require the Secretary to implement peer review of part A and part B services furnished by HMOs and CMPs. The provision would be effective upon enactment.

Conference agreement

The conference agreement includes the Senate amendment with a modification and changes the effective date of the provision to January 1, 1987. This clarifies an ambiguity that had been raised about current law. The conferees intend that the Secretary allocate sufficient additional funds to the PROs for the performance of the required functions and to recognize the unique features of HMO and CMP delivery of services in implementing this provision.

The conferees understand that the HMO/CMP industry is in the process of developing its own quality assurance capabilities. Conferees intend to review this approach prior to the effective date of this provision.

*59. Substitute review pending termination of a PRO contract**Present law*

A Peer Review Organization (PRO) which has a contract with the Health Care Financing Administration (HCFA) has exclusive authority to review utilization and quality of services as specified under Title XI of the Social Security Act. The Secretary may terminate a PRO contract for nonperformance provided certain proce-

dures are followed. These procedures require the Secretary to "provide the organization with an opportunity to provide data, interpretations of data, and other information pertinent to its performance under the contract." The data is to be reviewed by a panel appointed by the Secretary and the findings submitted to the Secretary and made available to the organization. The Secretary may accept or not accept the panel's findings. The Secretary may, with the concurrence of the organization, modify the scope of the contract. The Secretary may terminate the contract upon 90 days after the panel has submitted a report or earlier if the organization so agrees. The law does not make provision for assigning review (or backlogged review) to another entity during termination proceedings. Thus, terminations can create a period of several months where no utilization and quality review is conducted.

House bill

No provision.

Senate amendment

The provision would authorize the Secretary to assign review authority to another entity after the PRO has been notified of an intent to terminate its contract because the PRO is not performing effectively and prior to the time when a new PRO contract is awarded. The provision would be effective upon enactment.

Conference agreement

The conference agreement includes the Senate amendment.

60. Authorize peer review organizations to deny payment for substandard care

Present law

Peer Review Organizations (PROs) may review, subject to the provisions of their contracts, the professional activities of physicians, other practitioners and institutional and noninstitutional providers in rendering services to medicare beneficiaries. The review is to focus on: (a) the medical necessity and reasonableness of care; (b) the quality of care; and (c) the appropriateness of the setting. The law specifies that the determinations of the PRO with respect to medical necessity reviews and reviews of the appropriateness of the setting are generally binding for purposes of determining whether benefits should be paid. Despite the fact that PROs are required to conduct quality reviews, they are not authorized to deny payment for care of substandard quality.

House bill

No provision.

Senate amendment

The provision would authorize PROs to deny payment for care of substandard quality that is identified through criteria developed according to a plan approved by HCFA. The provision would be effective upon enactment.

Conference agreement

The conference agreement includes the Senate amendment with a modification specifying that beneficiaries are to be protected by the waiver of liability provisions against being charged for services for which medicare payment is denied. Further, the agreement requires the criteria to be developed pursuant to guidelines established by the Secretary.

TITLE IX

SUBTITLE B—MEDICAID AND MATERNAL AND CHILD HEALTH PROVISIONS

1. Services for Pregnant Women (Section 9501)

Present law

The Deficit Reduction Act of 1984 (P.L. 98-369) requires the States to cover under Medicaid, from the date of medical verification of pregnancy, certain pregnant women, if they meet State AFDC income and resource requirements, as follows: (a) pregnant women who would be eligible for AFDC and Medicaid if their child were born; and (b) pregnant women in two-parent families where the principal breadwinner is unemployed.

House bill

(a) *Mandatory coverage.* Requires States to cover under Medicaid pregnant women in two-parent families that meet AFDC income and resource standards even where the principal breadwinner is not unemployed.

(b) *Targeted services.* Specifies that States are not required to extend comparable benefits to other beneficiaries when they provide additional services related to pregnancy (including prenatal, delivery, and post-partum services) or its complication to all covered pregnant women.

(c) *Post-partum coverage.* Requires States to provide post-partum coverage to eligible pregnant women until the end of the 60-day period beginning on the last day of their pregnancy.

Senate amendment

(a) *Mandatory coverage.* No provision.

(b) *Targeted services.* Similar provision.

(c) *Post-partum coverage.* Permits a State to provide such coverage if it does so for all pregnant women covered under the plan. Covered services for this population group may be limited to post-partum care.

Conference agreement

(a) *Mandatory coverage.* The conference agreement follows the House bill.

(b) *Targeted services.* The conference agreement follows the Senate amendment with a clarification that services relating to any other condition which may complicate pregnancy are included in this exception to the general comparability requirement.

(c) *Post-partum coverage.* The conference agreement follows the House bill.

Effective dates. The mandatory coverage provision applies to Medicaid payments for calendar quarters beginning on or after April 1, 1986, without regard to whether or not final regulations to carry out the amendments have been promulgated by that date. Delay is permitted where State legislation (other than legislation appropriating funds) is required. All other provisions take effect on the date of enactment.

2. Modifications of Home and Community-Based Waiver (Section 9502)

Present law

(a) *Eligibility for Ventilator-Dependent Persons.* Section 1915(c) of the Social Security Act authorizes the Secretary of HHS to waive certain Medicaid requirements to allow States to provide a variety of home and community-based long-term care services to individuals who would otherwise require the level of care provided in a SNF or ICF whose cost could be reimbursed under the State's Medicaid plan.

(b) *Needs Allowances.* Regulations require the income of beneficiaries of home and community-based care to be applied to the cost of this care, after deductions have been made for maintenance needs.

(c) *Habilitation Services.* States may cover the following services under waivers: case management, homemaker/home health aid services, personal care, adult day health, habilitation services, respite care, and such other services requested by the State and approved by the Secretary. With regard to habilitation services, final regulations excluded prevocational and vocational training and educational activities from services which may be covered.

(d) *Waiver Approval.* In order to receive approval for a waiver, States must provide a number of assurances to the Secretary, including one requiring that the estimated average per capita expenditure for medical assistance under the waiver for those receiving waived services in any fiscal year not exceed the average per capita expenditure that the State reasonably estimates would have been incurred in that year for that population if the waiver had not been granted. This has been interpreted to require a showing by States that estimated average per capita expenditures under the waiver will not exceed 75 percent of the average per capita expenditures the State estimates would have been incurred in the absence of the waiver. Final implementing regulations published March 13, 1985, also require States to assure that the actual total expenditures for home and community-based services under the waiver will not exceed the State's approved estimated expenditures and that the State will not claim Federal matching payments for expenditures exceeding the approved estimate.

(e) *One Year Waiver Extension.* A home and community-based waiver is granted for an initial term of 3 years, and, upon the request of a State, can be renewed for additional 3-year periods, unless the Secretary determines that certain assurances have not been met.

(f) *Five Year Waiver Renewals.* Same as (e).

(g) *MCH Block Grant Coordination.* Under the waiver authority, States are providing home and community-based services to a number of groups of individuals, including children. Title V of the Social Security Act, known as the Maternal and Child Health (MCH) Block Grant, authorizes grants to the States for a variety of maternal and child health services, including services for children with special health care needs.

(h) *Substitution of Participants.* Under the waiver authority, a State may provide a variety of home and community-based services to individuals who would otherwise require the level of care provided in an SNF or ICF, cost of which could be reimbursed under the State's Medicaid plan. Regulations require States, in their applications to provide home and community-based services, to describe the group or groups of individuals to whom services will be offered and to estimate the unduplicated number of recipients who will receive services in a given year. This has been interpreted to mean that individuals who receive services in a given year and who die, enter a nursing home, or otherwise drop out of the home and community-based care program during that year, cannot be replaced in that year with other individuals who would be eligible to receive such services.

House bill

(a) *Eligibility for Ventilator-Dependent Persons.* Includes ventilator-dependent individuals who receive inpatient hospital services among those individuals eligible for expanded home and community-based services.

(b) *Needs Allowances.* Allows States to establish for individuals receiving waived services in the community higher maintenance needs allowances than maximum amounts allowed under regulations in effect July 1, 1985.

(c) *Habilitation Services.* Defines habilitation services as services designed to assist individuals to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings, and includes pre-vocational, educational, and supported employment services. Habilitation services would not include special education and related services as defined in the Education of the Handicapped Act which otherwise are available through a local educational agency, nor would they include vocational rehabilitation services which otherwise are available through a program funded under the Rehabilitation Act of 1973.

(d) *Waiver Approval.* Clarifies that the estimated average per capita expenditure for medical assistance under the program in any fiscal year must not exceed 100 percent of the average per capita expenditures that the State reasonably estimates would have been incurred in that year if the waiver had not been granted.

Prohibits the Secretary from requiring that the actual total expenditures for home and community-based services under the waiver, and the associated claim for Federal matching payments, can not exceed the approved estimates for these services.

Prohibits the Secretary from denying Federal matching payments for home and community-based services on the ground that

a State has failed to limit actual total expenditures for home and community-based services under the waivers to the approved estimates for these expenditures.

Allows States, in estimating the average per capita expenditures for physically disabled individuals in ICFs, to use only the expenditures associated with that group of patients and not expenditures associated with non-disabled individuals.

(e) *One Year Extension*. No provision.

(f) *Five Year Waiver Renewals*. No provision.

(g) *MCH Block Grant Coordination*. No provision.

(h) *Substitution of Participants*.—No provision.

Senate amendment

(a) *Eligibility for Ventilator-Dependent Persons*. No provision; however, section 720 of Senate amendment amends Medicaid to require States to cover respiratory services for qualified respiratory care patients.

(b) *Needs Allowance*. No provision.

(c) *Habilitation Services*. No provision.

(d) *Waiver Approval*. No provision.

(e) *One Year Waiver Extension*. Requires the Secretary to extend, for a period of 1 year at a minimum or 5 years at a maximum, any waiver that expires during the 12-month period beginning September 30, 1985, if the State requests an extension.

(f) *Five Year Waiver Renewals*. Requires the Secretary, beginning September 30, 1986, to renew home and community-based services waivers for additional 5-year periods if the Secretary approves the waiver renewal request.

(g) *MCH Block Grant Coordination*. Amends the waiver authority to require the State Medicaid agency, whenever appropriate, to enter into cooperative arrangements with the State agency administering the MCH Block Grant program of services for children with special health care needs. These cooperative arrangements must provide that individuals under 18 who are eligible for home and community-based services will be referred to the State agency administering the MCH program for children with special health care needs.

In addition, the State MCH agency would be required to assure: (1) the establishment of an individual service plan for the child; (2) the designation of a case manager to assist the family in carrying out the plan; and (3) the monitoring of the utilization, quality, and costs of services provided for appropriateness and reasonableness.

(h) *Substitution of Participants*. Amends the home and community-based waiver authority to specify that for waivers which contain a limit on the number of individuals who will receive home and community-based services, the State may substitute additional individuals for any individuals who die or become ineligible for services.

Conference agreement

(a) *Eligibility for Ventilator-dependent Persons*. The conference agreement follows the House bill.

(b) *Needs Allowances*. The conference agreement follows the House bill.

(c) *Habilitation Services*. The conference agreement follows the House bill.

(d) *Waiver approval*. The conference agreement follows the House bill.

(e) *One Year Waiver Extension*. The conference agreement follows the Senate amendment. The conferees intend that waivers extended under this provision are subject to the same Secretarial monitoring and compliance procedures as all other home and community-based services waivers.

(f) *Five Year Waiver Renewals*. The conference agreement follows the Senate amendment.

(g) *MCH Block Grant Coordination*. The conference agreement follows the Senate amendment. The conferees intend that the use of cooperative arrangements be optional with the States and that the use of MCH agencies as case managers be optional with beneficiaries covered under the waiver.

(h) *Substitution of Participants*. The conference agreement follows the Senate amendment.

Effective dates

(a) *Eligibility for Ventilator-dependent Persons*. Effective for services furnished on or after October 1, 1985.

(b) *Needs Allowances*. Effective for waiver or renewal applications filed before, on, or after the date of enactment.

(c) *Habilitation Services*. Effective for services furnished on or after enactment.

(d) *Waiver Approval*. Effective for waiver or renewal applications filed before, on, or after the date of enactment, and for services furnished on or after August 13, 1981.

(e) *One Year Waiver Extension*. Effective for waivers expiring on or after September 30, 1985, and before September 30, 1986.

(f) *Five Year Waiver Renewals*. Effective on September 30, 1986.

(g) *MCH Block Grant Coordination*. Effective on the date of enactment.

(h) *Substitution of Participants*. Effective on the date of enactment.

3. Home and Community-based Services Demonstrations. (Section 9513)

Present law

No comparable provision.

House bill

No provision.

Senate amendment

Requires the Secretary of HHS to conduct demonstrations in four States to determine whether, and to what extent, State-controlled home and community-based services programs for elderly, disabled, and developmentally disabled Medicaid-eligible individuals can reduce expenditures for society as a whole, the Federal government, and/or the States. Under the demonstrations, expenditures would exceed the amounts which would otherwise be expended

under the States' Medicaid plans for services provided to the same individuals by not less than \$85,000,000 nor more than \$88,000,000 for all four projects over the 3-year period of the projects. These additional amounts may be used to provide additional services such as habilitative services not otherwise covered under the State's Medicaid plan or care provided in small facilities not otherwise eligible for payments under the State plan, but all standards for quality of care otherwise applicable under the State plan would apply. In selecting the four States to carry out the demonstration projects, the Secretary would be required to select programmatically and demographically disparate States.

Requires the Secretary to evaluate the demonstration projects and to submit a preliminary report during the third year of the projects. Requires that the evaluation be funded at a level of not less than \$1,500,000 nor more than \$2,000,000.

Conference agreement

The conference agreement follows the Senate amendment with a modification providing that at least one of the four demonstration projects include the provision of home and community-based services for a substantial number of persons with Alzheimer's and related disorders, and that at least one of the other demonstration projects address services for mentally retarded and developmentally disabled Medicaid beneficiaries. The conference agreement also clarifies that beneficiaries participating in these demonstration projects will not experience any reduction or delay in benefits or services to which they are entitled under the regular State Medicaid plan. In addition, the conference agreement clarifies that the funding provided for these demonstrations is Medicaid entitlement funding, subject to regular State matching requirements.

The purpose of these demonstration projects is to determine the cost of expanding the availability of home and community-based services as an alternative to institutional long term care. The conferees recognize that the budget neutrality requirement of the current home and community-based waiver provision does not allow the States the flexibility to determine the cost of expansion of services because current waiver programs must be designed within existing spending levels. Under these demonstrations, however, a State's expenditures can exceed the amounts which would otherwise be spent under the State's Medicaid plan for services to the same individuals.

With regard to the demonstration concerning Alzheimer's and related disorders, the conferees intend that the project should specifically address the criteria for determining who is eligible for services as an Alzheimer's or related disorder patient, the range of services needed, and the cost of care for such patients. The conferees expect that the project relating to the mentally retarded and developmentally disabled population will address the cost, range and quality of services needed and the appropriateness of home and community-based care for this population.

Since the individuals participating in these demonstrations are otherwise eligible for Medicaid, the funds provided under this section are intended to support new and expanded benefits that are otherwise unavailable to these individuals under the State's Medic-

aid plan, such as habilitation services and respite care. The conferees do not intend the conduct of these demonstrations to restrict the benefits available under the State's plan, or otherwise impair and entitlement of any Medicaid-eligible individual participating in the demonstration. This section does not authorize the demonstration of a block grant for ICF/MR services.

The conferees are particularly concerned that these demonstrations attempt to assess the extent to which there are individuals in need of long-term care services who are not now receiving care, but would seek care if services in the community were expanded. The question of induced demand for services (the so-called "woodwork effect") is a major unresolved issue in current policy debates regarding the cost of expanding the availability of home and community-based services for the frail elderly and disabled. The conferees expect that one of the research objectives of these demonstrations will be to test whether a "woodwork effect" exists and, if so, to estimate its size and cost.

In determining whether and to what extent home and community-based waivers reduce expenditures, the conferees intend that the demonstration project evaluation will assess the impact of such services on the utilization and cost of both acute care and long term care services. For those participants eligible for both Medicare and Medicaid, the conferees intend that the costs and/or savings to both programs be separately evaluated.

The conferees are also interested in determining whether home and community-based services under Medicaid are newly offered services or whether they substitute for service currently available under other programs, such as Title XX of the Social Security Act. The conferees expect that the evaluation will determine whether expanding Medicaid home and community-based care improves access to such services or merely changes the financing for existing services.

Effective Date. Effective on enactment.

4. Task Force on Technology-Dependent Children. (Section 9520)

Present law

No comparable provision.

House bill

Requires the Secretary to establish, within 6 months after enactment of this Act, a task force concerning alternatives to institutional care for technology-dependent children. Requires the task force to submit, not later than two years after enactment of this Act, a final report to the Secretary and Congress on (1) barriers that prevent the provision of appropriate care in a home or community-setting to technology-dependent children, and (2) recommended changes in the provision and financing of health care in private and public health care programs so as to provide home and community-based alternatives for these children.

Senate amendment

Identical provision.

Conference agreement

The conference agreement follows the House bill.

Effective Date. Effective on enactment.

5. *Medicaid Coverage of Respiratory Care Services for Ventilator-Dependent Individuals. (Section 9504)*

Present law

States are required to cover home health services for Medicaid beneficiaries over 21 who are categorically needy. In addition, a State must provide home health services to (1) categorically needy beneficiaries under 21 if such individuals are eligible to receive skilled nursing facility services under a State's Medicaid plan, or (2) medically needy beneficiaries if SNF services are offered to that group. States may provide such services to other program beneficiaries if they are offered to all eligible beneficiaries.

House bill

No provision.

Senate amendment

Requires States to cover respiratory services in the home for individuals who (1) are medically dependent on a ventilator for life support at least 6 hours per day; (2) have been so dependent for at least 30 consecutive days or the maximum number of days authorized under the State plan, whichever is less, as inpatients in one of more hospitals, SNFs, or ICFs, and who, but for home respiratory care, would require respiratory care in these institutions; (3) have adequate social support services to be cared for at home; and (4) wish to be cared for at home.

Conference agreement

The conference agreement follows the Senate amendment with a modification providing that respiratory care services are an optional Medicaid benefit. Respiratory care services are defined as services provided on a part-time basis at the home of the eligible ventilator-dependent individual by a respiratory therapist or other health care professional trained in respiratory therapy (as determined by the State) for which payment is not otherwise made under the State plan within the payments for other items or services. The conferees expect that the Secretary, in regulations implementing this provision, will take particular care to assure that payment is not made twice for the respiratory care services, either because this service is already covered in the charge for ventilator or related equipment, or because the patient is also receiving nursing or other home care services that include the provision of respiratory care services.

Effective Date. Effective with respect to services furnished on or after April 1, 1986.

6. *Optional Hospice Benefits (Section 9505).*

Present law

States may cover some services that make up the hospice benefit package, such as home health care and prescription drugs. However, hospices are not recognized as providers for payment purposes, and States may not pay for comprehensive hospice services as a package. In addition, States may not offer services in the hospice package to terminally ill beneficiaries without offering those same services to all beneficiaries.

House bill

Allows States to cover hospice care as an optional Medicaid benefit. Hospice services could be provided to terminally ill individuals who have voluntarily elected to receive hospice care instead of certain other benefits. Hospice care would include the services included under Medicare. Hospice programs would be required to meet Medicare's requirements for organization and operation, and be public or nonprofit. The amount, duration, or scope of hospice services could not be less than benefits under Medicare. States choosing to cover hospice would be required to use Medicare's prospective payment methodology and reimburse at Medicare's rates. Beneficiary elections of hospice care could be for a period or periods as the State may establish. Beneficiaries could revoke election. States could apply the same eligibility standards for patients receiving hospice care outside of institutions as they apply to institutionalized patients. Cost sharing would not be imposed on hospice patients.

Senate amendment

Similar provision. However, contains no further requirements with respect to: the nature of the hospice organization; the amount, duration, or scope of benefits; reimbursement; election periods; income eligibility standards; or cost sharing.

Conference agreement

The conference agreement follows the House bill with a modification to delete the limitation on participation by otherwise qualified for-profit entities. The agreement also clarifies that, if an eligible individual who is a patient in an SNF or ICF elects hospice coverage, the payment for that individual's care in the institution during the period covered by the election will be made by the responsible hospice. The State's payment rate to the responsible hospice for each day the patient resides in an SNF or ICF must be increased by the amount attributable to the cost of room and board in the SNF or ICF; the facility will be paid by the responsible hospice, not by the State.

Effective Date. Effective for services furnished on or after enactment.

7. Medicaid Payments of Direct Medical Education Costs of Hospitals

Present law

State Medicaid payments for inpatient hospital services must be reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to meet State and Federal laws and regulations and quality and safety standards.

House bill

(a) *Basis of payment.* Requires State Medicaid programs to pay hospitals for their direct medical education costs associated with approved medical residency training programs on the basis of a fixed amount per fulltime equivalent (FTE) resident.

(b) *Calculation of payment.* Provides that the payment to each hospital would equal the hospital's approved FTE resident amount, times the hospital's number of FTE residents, times the proportion of total inpatient days attributable to Medicaid patients.

(c) *Payment limitation.* Requires the Secretary to determine each hospital's allowable average cost per FTE resident by using data on the average reasonable direct medical education cost per FTE resident from the hospital's most recent audited Medicare cost report, updated by the actual and estimated change in the Consumer Price Index. Provides that a hospital's FTE resident amount may not exceed the following percentages of the national average FTE resident amount: 175 percent for the residency year beginning July 1, 1986; 150 percent for the residency year beginning July 1, 1987; and 125 percent for residency years beginning on or after July 1, 1988.

(d) *Counting of residents.* Requires the Secretary to establish rules for the computation of FTE residents which provide that only time spent in patient care activities be counted, that time spent in an outpatient setting be counted, and that residents who serve only a portion of their year with one or more hospitals be taken into account.

(e) *Weighting factors.* Requires that for residency years beginning July 1, 1987, a weighting factor be applied in calculating the number of FTE residents as follows:

WEIGHTING FACTORS

Residency year beginning in	Primary care residents	Other residents	
		During initial residency period	During any other period
1987	1.10	0.90	0.75
1988	1.20	.80	.50
1989 or later	1.30	.70	.50

Authorizes the Secretary, beginning July 1, 1989, to change the weighting factors or to establish an alternative method for calculat-

ing the number of FTE residents, based on recommendations of the Physician Payment Review Commission (as authorized by Section 152 of the House bill).

(f) *Primary care residents.* Defines "primary care resident" to mean an individual in the first 3 years of postgraduate medical training in the fields of internal medicine, pediatrics, or family medicine, and an individual in up to 2 years of training in geriatric medicine, health, or preventive medicine.

(g) *Initial residency period.* Defines "initial residency period" to mean the minimum number of years of formal residency training necessary to satisfy the requirements for initial board eligibility in a particular medical specialty, not to exceed 5 years; excludes up to 2 years of residency in the fields of geriatric medicine, public health, and preventive health.

(h) *Foreign medical graduates.* Provides that foreign medical graduates (i.e., graduates of medical schools not accredited by a body or bodies approved by the Secretary of Education) may not be counted as residents beginning July 1, 1986, unless they have passed parts I and II of the Foreign Medical Graduate Examination in the Medical Sciences (FMGEMS). Foreign medical graduates who began serving as residents before July 1, 1986, and serve as residents during that year but have not passed the FMGEMS examination before July 1, 1986, would be counted at one-half the rate at which the resident would otherwise have been counted. Authorizes the Secretary to treat an individual as having passed the FMGEMS examination if the individual is unable to take that examination because they previously received certification from the Educational Commission for Foreign Medical Graduates.

(i) *Report.* Requires the Secretary to report to Congress, not later than Dec. 31, 1986, on whether the new Medicaid payment methodology for direct medical education costs should be revised to provide for greater uniformity in the approved FTE resident amounts and, if so, how such revisions should be implemented.

Senate amendment

No provision directly amending the Medicaid statute.

Conference agreement

The conference agreement does not include the House provision. See section 9202, concerning Medicare payments to hospitals for direct costs of medical education, which affects State Medicaid programs that elect to follow Medicare principles.

8. Treatment of Potential Payments from Medicaid Qualifying Trusts (Section 9506)

Present law

Under Medicaid, only income and resources actually available to an individual are considered in determining eligibility. The law contains no specific provision pertaining to income from trusts.

House bill

(a) *Definition of available amounts.* Specifies that for purposes of Medicaid eligibility, the distributions from certain Medicaid quali-

fying trusts would be considered available to the individual establishing the trust whether or not the distributions are actually made. The amount deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust assuming the full exercise of discretion by the trustee or trustees.

(b) *Definition of trust.* Defines a "Medicaid qualifying trust" as a trust or similar legal device established by an individual (or his or her spouse) under which the individual is the beneficiary of all or part of the payments from the trust and the amount of such distribution is determined by one or more trustees who are permitted to exercise any discretion with respect to the amount to be distributed to the individual. Clarifies that the provision applies: (1) whether or not the Medicaid qualifying trust is irrevocable or is established for purposes other than to enable the individual to qualify for Medicaid; and (2) whether or not the trustee(s) actually exercise discretion with respect to the amount of funds distributed.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with a modification authorizing States to refrain from applying this provision to individuals in cases where undue hardship will result. While the conferees intend to discourage the establishment of the specified grantor trusts for the purpose of shielding assets from the State, the conferees also would expect States to waive application of this provision in cases where undue hardship would occur. For example, the conferees do not expect a State to deny Medicaid coverage to an individual under this section if he or she would be forced to go without life-sustaining services altogether because the trust funds could not be made available to pay for the services.

This provision addresses only eligibility for Medicaid, not eligibility for Supplemental Security Income or Aid to Families with Dependent Children. The conferees do not intend that the enactment of this provision be interpreted to have any bearing on eligibility policy in either of those cash assistance programs. It is also the understanding and intent of the conferees that this provision will have no effect on current law with regard to the treatment of such trusts in the context of estate proceedings.

In those States where, pursuant to section 1634 of the Social Security Act, the Secretary is making Medicaid eligibility determinations with respect to Supplemental Security Income beneficiaries, the conferees expect that the Secretary and the States will integrate the determinations required under this section into their current arrangements in a manner satisfactory to the Secretary.

Effective Date.—Applies to medical assistance furnished on or after the first day of the second month beginning after the date of enactment.

9. *Written Standards for Provision for Organ Transplants (Section 9507)*

Present law

No provision.

House bill

Denies Federal matching payments for organ transplant services provided to Medicaid beneficiaries unless the State plan provides for written standards for the coverage of such services and unless the standards treat similarly situated individuals alike. If such standards impose restriction on the facilities or practitioners who may provide such services, the restrictions must be consistent with the accessibility of high quality care by Medicaid patients.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

Effective Date.—Applies to medical assistance furnished on or after January 1, 1987.

10. *Extension of MMIS Deadline. (Section 9518)*

Present law

States are generally required to have mechanized claims processing and information retrieval systems, known as "Medicaid management Information Systems" (MMIS), that are annually reviewed and approved by the Health Care Financing Administration. The systems are designed to improve the capability of State Medicaid agencies to process claims on an accurate and timely basis and to provide data for administration of the Medicaid program.

The current deadline for a State to operate such a system is the earlier of (a) September 30, 1982, or (b) the last day of the sixth month following the date specified for operation of such systems in the States most recently approved advance planning document submitted before the enactment of P.L. 96-398 (October 7, 1980).

House bill

The deadline for State compliance with Federal performance standards for the operation of a Medicaid management information system is extended to September 30, 1985.

Senate Amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

Effective Date.—Applies to payments to States for calendar quarters beginning on or after October 1, 1982.

11. Extension of Certain Texas Waiver Project. (Section 9523)

Present law

Section 1115 of the Social Security Act provides the Secretary of HHS general authority to conduct experiments and demonstrations under Medicaid and to waive program requirements in conducting these demonstrations. Under this authority, the Secretary has approved a waiver for the demonstration project, "Modifications of the Texas System of Care of the Elderly: Alternatives to the Institutionalized Aged," for the period January, 1980, through December, 1985.

House bill

Requires the Secretary to extend until December 31, 1988, approval of the waiver for the demonstration project, "Modifications of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged," and to continue the approval on the same terms and conditions as applied to the project as of the date of enactment of this Act. Also specifies that approval remain in effect until such time as the Secretary finds that the applicant no longer complies with these terms and conditions.

Senate amendment

Similar provision, except requires the Secretary to extend approval of the waiver for this demonstration until January 1, 1989. Does not require the Secretary to continue the approval on the same terms and conditions as applied to the project on date of enactment of the Act.

Conference agreement

The conference agreement follows the House bill with a modification that the waiver be extended until January 1, 1989.

Effective Date.—Effective on enactment.

12. Report on Adjustment in Medicaid Payments for Hospitals Serving Disproportionate Numbers of Low Income Patients. (Section 9519)

Present law

The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) required States, in developing their payment rates for inpatient hospital services, to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs.

House bill

Requires the Secretary to submit to Congress a report (1) describing the methodology used by States to take into account the situation of disproportionate share hospitals when determining their Medicaid payments to hospitals, (2) identifying hospitals that have received a disproportionate share adjustment, and (3) specifying the proportion of low income and Medicaid patients at such hospitals.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with a modification providing that the Secretary transmit the report to Congress no later than October 1, 1986.

13. References to Provisions of Law Providing Coverage Under, or Directly Affecting, the Medicaid Program. (Section 9526)

Present law

No provision.

House bill

A section is added to Title XIX (the Medicaid title) of the Social Security Act which provides references to laws directly affecting the Medicaid program. This allows readers of the title to more easily locate provisions of law that make additional individuals eligible for Medicaid, and that establish additional requirements for State plans to be approved under Medicaid.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

14. Third Party Liability Collections. (Section 9503)

*Present law**(a) State Plan Requirements*

Medicaid is intended to be the payer of last resort; that is, other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program. The law requires the State plan to provide that:

(1) the State of local agency administering the plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care;

(2) that where such agency knows that a third party has legal liability it will treat the liability as a resource of the individual for purposes of eligibility determinations; and

(3) the agency will seek reimbursement from liable third parties where payment has already been made where the expected amount of recovery exceeds the costs of recovery.

(b) Mechanized Claims Processing Systems

States are generally required to have Medicaid management information systems (MMIS) that are reviewed and approved by HCFA each year. The Secretary is required to develop performance standards, system requirements and other conditions for use in approval of such systems.

(c) Regulations

No provision.

(d) Conditions of Medicaid Eligibility

Current law requires Medicaid beneficiaries to assign their rights to medical support payments and other payments for medical care to the State.

(e) Penalties for Erroneous Excess Payments

If a State makes erroneous excess payments exceeding allowable rates, Federal financial participation is reduced.

House bill

No provision.

*Senate amendment**(a) State Plan Requirements*

(1) Amends the law to specify that reasonable measures for ascertaining the legal liability of third parties include:

(i) collection of sufficient information (as specified in regulations) to enable the State to pursue claims with such information collected at the point of eligibility determinations, and

(ii) submission of a plan to the Secretary for pursuing claims. This plan is to be monitored by the Secretary as part of the review of the claims processing system and be subject to penalties for failing to meet conditions of approval, and

(iii) all other penalties, such as audit disallowances for third-party liability, are prohibited.

(2) Clarifies that the person furnishing the service to a Medicaid eligible may not collect cost-sharing amounts if total third-party liabilities at least equal the amount otherwise payable under Medicaid. Cost-sharing may not exceed the lesser of the amount the beneficiary would be required to pay in the absence of third-party liability or the difference between such liability and the Medicaid payment amount. Violation of this provision could subject the person to a sanction equal to up to three times the amount sought to be collected.

(3) Clarifies that a person furnishing services may not refuse to furnish services to a Medicaid eligible because of a third-party's potential liability.

(b) Mechanized Claims Processing Systems

(1) Requires the Secretary to develop performance standards for assessing States' third-party liability collection efforts which are to be integrated with and monitored as part of the Secretary's review of each State's MMIS.

(2) Provides that reviews of MMIS may be conducted once every three years and may, at the Secretary's discretion, be either total reviews or focused reviews.

(c) Regulations

Requires issuance of regulations to implement (a) and (b) above within six months of enactment.

(d) Conditions of Medicaid Eligibility

Requires individuals, as a condition of eligibility, to cooperate with the State in identifying and pursuing liable third parties unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary.

(e) Penalties for Erroneous Payments

Disregards, for purposes of this calculation, errors resulting from failure of an individual to cooperate or give correct information relating to third-party liability.

*Conference agreement**(a) State plan requirements*

The conference agreement follows the Senate amendment with a modification that third party payments for preventive pediatric care, including Early and Periodic Screening, Diagnosis, and Treatment services, as well as those for prenatal care, must be pursued by the State, not by the provider. The conferees are concerned that the administrative burdens associated with third party liability collection efforts not discourage participation in the Medicaid program by physicians and other providers of preventive pediatric and prenatal care, since the beneficiaries in need of such services already have difficulty finding quality providers in many communities. The conference agreement therefore provides that, in the cases where preventive pediatric and prenatal services are rendered to a beneficiary for whom a third party is potentially liable, the State make payment to the provider according to the normal payment schedule and pursue the third party payment itself.

The conference agreement further provides that, in the case of beneficiaries on whose behalf a child support enforcement is being carried out by a State agency under Title IV-D, the State Medicaid agency will seek to collect from the third party if, after 30 days of delivering the services in question, the provider has not received payment. The intent of the conferees is to protect the mother and her dependent children from having to pursue the absent spouse, or his employer or insurer, for third party liability.

(b) Mechanized claims processing systems

The conference agreement follows the Senate amendment.

(c) Regulations

The conference agreement follows the Senate amendment.

(d) Conditions of Medicaid Eligibility

The conference agreement follows the Senate amendment with a modification clarifying that individuals are required to identify, to the extent they are able, potentially liable insurers and other third parties, and to provide information to assist the State in pursuing third parties. Beneficiaries are not required to pursue the collec-

tions themselves. Pursuit is the responsibility of the provider or the State as provided elsewhere in this section.

The conferees note that the fact that an insurer or other third party is potentially liable for the costs of an individual's care does not, of course, mean that this coverage constitutes a resource for purposes of Medicaid eligibility. If the applicant or beneficiary actually receives a cash payment from a third party by way of indemnification for a medical expense, and if this payment were not somehow already assigned to the State, then the payment so received would be considered a resource for Medicaid eligibility purposes. In all other circumstances, the health insurance or benefits coverage is not to be considered a resource.

(e) Penalties for Erroneous Payments

The conference agreement follows the Senate amendment.

Effective Date.—The requirement that the Secretary promulgate regulations is effective on the date of enactment. All other requirements take effect with respect to calendar quarters beginning on or after the date of enactment, except that delay is permitted where State legislation (other than appropriations legislation) is required. No penalty may be applied against a State for violations of State plan requirements occurring before the effective date of these amendments.

15. Optional Targeted Case Management Services (Section 9508)

Present law

“Case management” is commonly understood to be a system under which responsibility for locating, coordinating, and monitoring a group of services rests with a designated person or organization. Under current Medicaid law, case management is not included among the list of medical services which may be covered under a State's Medicaid plan. However, States may include case management services under freedom-of-choice and home and community-base services waivers authorized under section 1915(b) and 1915(c) respectively. In addition, States may receive administrative funds under their Medicaid plans for certain case management activities (for example, preadmission screening) when offered to all Medicaid beneficiaries in all areas of the States.

House bill

No provision.

Senate amendment

Allows States to cover case management services without regard to requirements that Medicaid services be available throughout a State and that covered services be equal in amount, duration, and scope for certain Medicaid beneficiaries. Defines case management services as services which will assist individuals eligible under Medicaid in gaining access to needed medical, social, educational, and other services.

Conference agreement

The conference agreement follows the Senate amendment with a modification clarifying that beneficiaries cannot be locked into designated providers under targeted case management services, whether for the case management services themselves or other services. The conferees expect that the Secretary will assure that payments made for case management services under this section do not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. The conference agreement also provides that, with respect to family planning services, the right of Medicaid beneficiaries to choose their own providers may not be restricted under any waivers granted under section 1915(b) of the Social Security Act.

Effective Date.—Effective for services furnished on or after enactment.

16. Modify Revaluation of Assets Provision (Section 9509)

Present law

Under section 2314 of the Deficit Reduction Act of 1984, the “revaluation of assets” provision, Medicare payments to nursing homes may not be increased to reflect higher capital costs that result solely from the sale of such facilities. Capital costs recognized for reimbursement include depreciation, interest expense, and in the case of proprietary providers, return on equity. Capital-related costs to the new owner are based on the lesser of (1) the allowable acquisition cost to the prior owner (i.e., the historical cost, net of depreciation), or (2) the acquisition cost to the new owner. Medicaid payments are subject to a similar limit with States required to provide assurances, satisfactory to the Secretary, that methodologies used to establish rates paid to nursing homes can reasonably be expected not to increase those rates more than they would under Medicare policy as a result of a change in ownership.

House bill

No provision.

Senate amendment

Amends the Medicaid revaluation of assets provision to allow a State’s aggregate capital cost payments to nursing homes to reflect increases in their valuation due to changes in ownership. The revaluation, however, would be limited to the acquisition costs of the previous owner increased by one-half the percentage increase in the Dodge Construction Index for Nursing Homes applied in the aggregate to those facilities which have changed ownership, or one-half the percentage increase in the CPI, whichever is lower.

Requires GAO to conduct a study of the effects of these amendments and to report the results of the study two years after the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment. It is the understanding of the conferees that the Senate report language

regarding reduction by the previously allowed depreciation does not govern.

Effective Date.—October 1, 1985, but only with respect to changes in ownership occurring on or after such date.

17. Beginning Date of Optional Coverage for Individuals in Medical Institutions (Section 9510)

Present law

States may provide Medicaid coverage for individuals who are in medical institutions but who have too much income to qualify for cash payments under the Supplemental Security Income Program. The income standard which a State applies to this optional coverage group cannot exceed 300 percent of the SSI benefit amount payable to an aged, blind or disabled individual in his or her own home who has no other income or resources. Implementing regulations specify that the State Medicaid agency shall apply the special income standard beginning with the first full calendar month of institutionalization.

House bill

No provision.

Senate amendment

Substitutes for the full calendar month test a requirement that payment begins at the beginning of any 30 consecutive-day period of institutionalization.

Conference agreement

The conference agreement follows the Senate amendment.

Effective Date.—Applies to services furnished on or after January 1, 1985.

18. Optional Coverage of Children (Section 9511)

Present law

States are able to cover under Medicaid all, or reasonable categories of, poor children under age 18 or 19 or 20 or 21 living in two parent families. These are known as "Ribicoff children." The Deficit Reduction Act required States to cover all children born on or after October 1, 1983, up to age 5, who meet AFDC income and resources requirements. The law requires that coverage for this population group be phased-in over a 5 year period starting with the youngest children. Federal matching is not available for children under age 5 born prior to October 1, 1983, unless the State extends coverage to all Ribicoff children other than those added by the Deficit Reduction Act provision.

House bill

No provision.

Senate amendment

Allows States to cover and receive Federal matching funds for all Ribicoff children under age 5 immediately.

Conference agreement

The conference agreement follows the Senate amendment.

Effective Date.—Applies with respect to payments for services furnished on or after October 1, 1985.

*19. Overpayment Recovery Rules (Section 9512)**Present law*

State Medicaid agencies are allowed to pay nursing homes and hospitals at interim rates until final rates are established. The State is responsible for the collection of any "overpayment" and must refund the Federal share of such overpayment to the Federal Government. Under current program administrative instructions, the State must refund the Federal share immediately upon discovering the overpayment. Refunds must be made for all overpayments even where they are not collectible because the providers have gone into bankruptcy or out-of-business.

House bill

No provision.

Senate amendment

Allows States up to sixty days (from the date of discovery) to recover overpayments from providers and refund the Federal share. Provides that a State is not liable for the Federal share of overpayments which cannot be collected from bankrupt or out-of-business providers.

Conference agreement

The conference agreement follows the Senate amendment.

Effective Date.—Applies to overpayments for quarters beginning on or after October 1, 1985.

*20. Expansion of Services Under Demonstration Waivers (Section 9522)**Present law*

Section 1903(m)(2) of the Social Security Act stipulates that States cannot contract on an at-risk basis with an entity which provides a certain number and type of services unless certain conditions are met. If any entity provides: (a) inpatient hospital services and any other mandatory Medicaid service, or (b) any three mandatory services, that entity must meet the specified standards before a State can enter into a risk contract with it for the provision of Medicaid services. The Secretary may not waive these requirements under the freedom-of-choice waivers under section 1915(b).

House bill

No provision.

Senate amendment

Authorizes the Secretary, with respect to entities providing services under a freedom-of-choice waiver, to waive the specified standards under section 1903(m)(2) if the entity does not provide more than five of the mandatory services and does not provide inpatient hospital services.

Conference agreement

The conference agreement follows the Senate amendment with an amendment limiting applicability to the State of Oregon. The conferees view this waiver as a demonstration program which will be reviewed and evaluated.

Effective Date.—Enactment.

21. *Life Safety Code Recognition (Section 9515)*

Present law

The Secretary of the Department of Health and Human Services may establish "standards of safety and sanitation" applicable to intermediate care facilities for the mentally retarded (ICFs/MR). Section 1905(c) of the Social Security Act requires intermediate care facilities (ICFs) to meet such standards prescribed by the Secretary as he/she finds appropriate for the proper provision of care and to meet such standards of safety and sanitation as established under regulation of the Secretary. These regulations refer to the 1981 Edition of the Life Safety Code of the National Fire Protection Association.

House bill

No provision.

Senate amendment

Requires the Secretary for purposes of section 1905(c) to specify the 1985 edition of the Life Safety Code of the National Fire Protection Association until such time as a new edition is published.

Conference agreement

The conference agreement follows the Senate amendment with an amendment limiting the provision to fire safety code requirements for ICF/MR and allowing the Secretary to use an updated life safety code or higher standards.

Effective Date.—Enactment.

22. *Publication of ICF/MR Regulations (Section 9514)*

Present law

At their option, States may cover in their Medicaid plans intermediate care facility services for the mentally retarded. These facilities must meet such standards as may be required by the Secretary. These standards were published in 1974 (42 CFR Subpart G).

House bill

No provision.

Senate amendment

Requires the Secretary to publish, within 60 days of enactment, proposed revisions to the standards for intermediate care facilities for the mentally retarded (ICFs/MR).

Conference agreement

The conference agreement follows the Senate amendment.

Effective Date.—Enactment.

23. *Modifying Application of Medicaid HMO Provisions for Certain Health Centers (Section 9517)*

Present law

(a) *Eligibility to Contract on a Risk Basis.* States can contract with certain organizations to provide health care services to Medicaid beneficiaries on a prepaid capitated basis. Among these organizations are: Community Health Centers and Migrant Health Centers, primarily funded by the Public Health Service, and certain rural health care centers known as Appalachian Health Centers, funded under the Appalachian Regional Development Act, that had existed prior to June 30, 1976.

(b) *Lock-in Provision.* States can restrict Medicaid beneficiaries from disenrolling without cause from certain organizations offering services on a prepaid capitated basis for periods of up to six months. This restriction is known as "lock-in." Organizations eligible to participate in the lock-in provisions include federally qualified HMOs, and Community, Migrant and Appalachian Health Centers that are receiving, and had received in each of the two preceding years, at least \$100,000 under the appropriate sections of the Public Health Service or Appalachian Regional Development Acts. In either case, the organizations must also meet the requirement that less than 75 percent of their enrolled members are receiving benefits under either Medicaid or Medicare.

(c) *Continuation of Benefits.* In the case of Medicaid beneficiaries who are enrolled in a federally qualified HMO contracting with a State Medicaid program and who would otherwise lose their Medicaid eligibility, States may deem these individuals eligible for Medicaid with respect to the services provided by the HMO for a period of up to 6 months.

House bill

No provision.

Senate amendment

(a) *Eligibility to Contract on a Risk Basis.* Allows States to contract on a risk basis with Community and Migrant Health Centers and Appalachian Health Centers that are receiving, and for the past two years have received, at least \$100,000 in grants under the appropriate sections of the Public Health Service and Appalachian Regional Development Acts.

(b) *Lock-in Provision.* Permits Community and Migrant Health Centers and Appalachian Health Centers that are contracting with the Medicaid program on a risk basis, and are receiving, and had received in each of the two preceding years, at least \$100,000 in grants under the appropriate sections of the Public Health Service and Appalachian Regional Development Acts to participate in the lock-in provision without regard to the 75 percent rule.

(c) *Continuation of Benefits.* Allows States to provide for continuation of benefits to individuals enrolled in certain Community, Migrant and Appalachian Health Centers on the same basis as individuals enrolled in federally qualified HMOs. The eligible Community, Migrant, and Appalachian Health Centers are those that are contracting as HMOs with the Medicaid program and are receiving, and had received in each of the two preceding years, at least \$100,000 under the appropriate sections of the Public Health Service and Appalachian Regional Development Acts.

Conference agreement

The conference agreement follows the Senate amendment with an amendment clarifying the applicability of current prepayment rules to Health Insuring Organizations (HIOs). According to a recent GAO Fact Sheet, "Medicaid Requirements: Health Insuring Organizations" (HRD-86-42FS, November, 1985), current HHS regulations and guidelines do not specify minimum qualifications for an HIO that arranges for the provision of services to Medicaid eligibles; do not specify the quality assurance methods that such an HIO must employ; do not specify the standards that an HIO must meet to assure access by program beneficiaries to services to which they are entitled; do not specify the amount of savings an HIO may retain for its own financial benefit; and do not specify the frequency or content of the utilization or financial reports that an HIO must submit with regard to the services for which its has arranged. In addition, the GAO Fact Sheet states that HIOs which arrange for the provision of services to Medicaid patients are not subject to specific regulatory requirements regarding financial reporting or ownership information. The conference agreement clarifies that where an HIO does more than simply act as a fiscal agent to review and process claims for payment, but actually arranges with other providers (through subcontract or otherwise) for the delivery of services to Medicaid eligibles (even though the HIO does not itself deliver services), it is subject to all of the regulatory requirements to which any health maintenance organization or similar prepaid entity is subject under current law.

Effective Date.—Enactment. The clarification with respect to HIOs applies to entities that first become operational after January 1, 1986.

24. *Use of Sampling for Medical Review in Mental Hospitals, Skilled Nursing Facilities, and Intermediate Care Facilities*

Present law

Requires that the care of each person receiving medical assistance in mental hospitals, SNFs, and ICFs be reviewed annually for the adequacy of services available, the necessity and desirability of continued placement in the facility, and the feasibility of alternative institutional or noninstitutional services.

House bill

No provision.

Senate amendment

Provides that medical reviews could be limited to a sample group of individuals receiving medical assistance in mental hospitals, SNFs, and ICFs, as permitted by the Secretary.

Conference agreement

The conference agreement does not include the Senate provision.

25. *Wisconsin Health Maintenance Organization Waiver (Section 9524)*

Present law

The Secretary of Health and Human Services may no longer waive the one-month disenrollment requirements for certain HMOs participating in a freedom-of-choice waiver.

House bill

No provision.

Senate amendment

Upon request by the State of Wisconsin, the Secretary of Health and Human Services is required to reinstate the waiver granted to the State of Wisconsin relating to HMO participation in the lock-in provision for renewable terms of 2 years, subject to the general requirements of such waivers.

Conference agreement

The conference agreement follows the Senate amendment.

Effective Date.—Enactment.

26. Clarification of Medicaid Moratorium Provisions of Deficit Reduction Act of 1984 (Section 9521)

Present law

(a) *Clarification.* The Deficit Reduction Act of 1984 prohibits the Secretary of the Department of Health and Human Services from taking any regulatory action against a State because the State uses less restrictive standards or methodologies in determining the eligibility of Medicaid beneficiaries who do not receive cash assistance than it does for those who do. The prohibition applies during a moratorium period that will end 18 months after the Secretary submits to the Congress her recommendations on the application of cash assistance eligibility standards and other methodologies to the "medically needy" and other non-cash Medicaid eligibles.

(b) *Restoration.* When it is determined that a Medicaid beneficiary who owns his or her own home could never return home, the value of his or her residence becomes a resource that can increase his or her resources beyond the permitted level. In the past, Federal Medicaid policy gave such an individual time to dispose of the property if he or she was making a bona fide effort to do so. Recent interpretations of these policies would tend to force premature sale of the homes of institutionalized Medicaid applicants and beneficiaries.

House Bill

No provision. (An identical provision regarding clarification was included in H.R. 1868 as passed by the House, H. Rept. 99-80, Part 2).

Senate amendment

(a) *Clarification.* Clarifies that the moratorium applies whether or not the less restrictive standards or methodologies applied by the State were explicitly stated and approved as part of a State's Medicaid plan.

(b) *Restoration.* Restores for the duration of the moratorium the previous Medicaid policy governing the period when home owner-

ship by an institutionalized individual is permitted and the period of time given for the sale of a home.

Conference agreement

(a) *Clarification.* The conference agreement follows the Senate amendment.

(b) *Restoration.* The conference agreement follows the Senate amendment with a technical amendment.

Effective Date.—Apply as though included in DEFRA as originally enacted.

27. *New Jersey Demonstration Project Relating to Training of AFDC Recipients as Home Health Aides (Section 9525)*

Present law

The "Omnibus Reconciliation Act of 1980" authorized the Secretary to enter into agreements for the purpose of conducting demonstration projects to train formally AFDC recipients as homemaker-home health aides. The bill authorized 90 percent Federal matching for the reasonable costs of conducting the projects. The projects were limited to a maximum of 4 years plus an additional period of up to 6 months for planning and development and a similar period for final evaluation and reporting. Several States, including New Jersey, conducted such demonstration projects.

House bill

No provision.

Senate amendment

Extends for one additional year, at 50 percent Federal matching, the demonstration project in the State of New Jersey.

Conference agreement

The conference agreement follows the Senate amendment.

Effective Date.—Enactment.

28. *Correction plans for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) (Section 9516)*

Present law

Section 1910(c) of the Social Security Act authorizes the Secretary to conduct validation, or "look behind," surveys to determine the validity of Medicaid certification actions taken by the designated State survey agency. Where the Secretary finds that a facility substantially fails to meet the requirements of participation in the Medicaid program, he/she is empowered to cancel the facility's provider agreement.

House bill

No provision.

Senate amendment

Provides that if the Secretary finds that an intermediate care facility for the mentally retarded (ICF/MR) has substantial deficiencies which do not pose an immediate threat to the health and safety of residents, the State may elect to submit a written correc-

tion plan. The plan must provide for (1) a timetable for completion of necessary steps to correct staffing deficiencies within 6 months, and a timetable for rectifying all physical plant deficiencies within 6 months, or (2) a timetable for permanently reducing the number of certified beds, within a maximum of 36 months, in order to permit any noncomplying buildings (or distinct parts thereof) to be vacated and any staffing deficiencies to be corrected.

If the Secretary finds at the conclusion of an initial 6-month period, or any subsequent 6-month period, that a State has substantially failed to meet its obligations established under a plan of correction, the Secretary may (1) terminate the facility's provider agreement, or (2) disallow (in the case of a planned reduction in a facility's population) an amount of Federal financial participation equal to 5 percent of allowable Medicaid cost for all eligible facility residents for each month the State fails to meet its interim goals.

Conference agreement

Under the conference agreement, if the Secretary finds that an ICF/MR has substantial deficiencies which do not pose an immediate threat to the health and safety of residents, the State has two options. It may either (1) implement a plan of correction, approved by the Secretary, to remedy any staffing and/or physical plant deficiencies within 6 months, or, (2) implement a plan, approved by the Secretary, to permanently reduce, within a maximum of 36 months, the number of certified beds in the noncomplying facility (or distinct parts thereof). If a State which has elected option (1) fails to make the necessary corrections within the 6-month period, the Secretary may terminate the provider agreement, as under current law. The conferees expect that prompt action will be taken to terminate the facility's provider agreement in such circumstances. If a State which has elected option (2) substantially fails to meet its interim reduction goals during any given 6-month period, the Secretary must either terminate the facility's provider agreement or disallow, for each month the State remains out of compliance, 5 percent of the Federal matching payments the State would otherwise receive for the cost of care of all residents in the facility.

The Secretary's authority to approve reduction plans under this section is effective only with the promulgation of final regulations implementing this provision. The Secretary is directed to publish, in the Federal Register, a notice of proposed rulemaking implementing this provision within 60 days of enactment. The notice must allow a 30-day comment period. The Secretary's authority to approve permanent reduction plans extends for 3 years from the effective date of the final regulations. States could continue implementation of permanent reduction plans approved during this 3-year period beyond the expiration date of the Secretary's authority to approve such plans, provided of course that the State continued to comply with the terms and conditions of plans as approved. The Secretary's responsibility to monitor and enforce compliance by the States with the terms of the approved plans does not lapse with the expiration of his authority to approve new plan applications.

No later than 6 months before the expiration of the Secretary's approval authority, the Secretary is directed to report to the Congress on the implementation and results of this section. The conferees expect that the Secretary will provide the Congress with information on the impact of both the correction plans and the reduc-

tion plans on the quality of life and the availability of active treatment for the Medicaid-eligible individuals who remain in the facilities in question and for those who are placed in community settings. The conferees also expect that the Secretary's report will detail the involvement of resident's families in the process of developing the correction or reduction plans and in the placement of affected patients.

During each of the 3 years that the Secretary's authority to approve reduction plans is in effect, the Secretary may approve, on a first come, first served basis, 15 plans that meet the requirements of this section. Thereafter, the Secretary may approve reduction plans that otherwise comply with this section only if the State can demonstrate, to the satisfaction of the Secretary, that the State would have to spend at least \$2,000,000 in State or local funds in order to remedy the substantial physical plant deficiencies found by the Secretary. There is no limit on the number of otherwise qualified plans that the Secretary may approve where the State meets the \$2,000,000 compliance cost threshold.

When the Secretary finds that an ICF/MR has substantial deficiencies, the State has the same period allowed under current law within which to submit a written plan of correction with the Secretary. If the State chooses to submit a written plan to permanently reduce the number of certified beds, it has the same period allowed under current law plus 35 days to accommodate the public hearing requirement described below. The Secretary must allow not less than 30 day after the submission of a proposed reduction plan by the State before approving or disapproving the proposal. During this period, interested residents, family, staff, and members of the public may comment directly to the Secretary on the State's proposal. The conferees expect that the Secretary will give careful consideration to these comments in connection with his decision.

The conference agreement imposes a number of requirements on States that elect to implement reduction plans rather than correct the deficiencies cited at the facility in question. The general purpose of these requirements is to assure that any such plan is well conceived; that it has had the benefit of resident, family, staff, and public input; and that the quality of life for both the residents remaining in the facility and those receiving community placements is adequately protected. While the conferees wish to allow the States some flexibility in the allocation of capital and staff resources between institutional and community settings, the conferees intend that fiscal concerns not compromise the accessibility or quality of services to Medicaid-eligible clients. Above all, it is the primary intention of the conferees that the Secretary, in administering this provision, take extreme care that reduction plans approved under this section do not lead to the "dumping" of affected residents into substandard settings.

As a condition of approval of a reduction plan, a State must provide for a hearing to be held at the affected facility at least 35 days prior to submission of the reduction plan, with reasonable notice to the staff and residents, the residents' families, and the general public. The purpose of this hearing is to facilitate discussion of a State's proposed plan by those most directly affected.

As a condition of approval, a State must also demonstrate to the Secretary that it has successfully provided home and community services similar to the services proposed to be provided under the

reduction plan for similar Medicaid-eligible individuals. The purpose of this provision is to assure that the State, from direct experience, developed the technical and administrative capacity to implement a reduction plan without harming the affected residents. The conferees expect that, at a minimum, the Secretary will review carefully the experience of the mentally retarded and developmentally disabled under the State's relevant home and community-based services waivers, if any.

In addition, any reduction plan must meet the following requirements. First, the plan must identify the number of existing facility residents that are to be provided home or community services, must describe their individual services needs, and must specify the timetable for providing such services, in 6-month intervals, within the 3-year period.

A reduction plan must describe the methods to be used (1) to select such residents for home and community services and (2) to develop the alternative home and community services to meet their needs effectively. The conferees intend that, in selecting the residents and meeting their service need, the States will use an interdisciplinary team process that provides an opportunity for participation by the resident's family.

A reduction plan must describe the necessary safeguards that will be applied to protect the health and welfare of the residents of the facility who are to be placed in community settings. These safeguards must include, at a minimum, participation by residents and family members and providers. In addition, the State must assure that community residences in which affected residents are placed meet all applicable State licensure requirements and all applicable State and Federal certification requirements. The conferees are particularly concerned that any community settings to which Medicaid-eligible residents are transferred comply fully with Federal certification requirements. The purpose of a reduction plan is to move Medicaid-eligible residents out of deficient facilities into complying settings.

A reduction plan must provide that residents of the affected facility who are eligible for Medicaid while in the facility shall, at their (or their legal guardian's) option, be placed in another setting, or another part of the affected facility, that is in full compliance with Federal Medicaid requirements and therefore allows them to retain their Medicaid eligibility. It is the firm intent of the conferees that a reduction plan not impair the Medicaid eligibility of an affected resident without their consent. If the resident would have remained eligible for Medicaid had the State opted to eliminate the deficiencies in the affected facility, then the State may not, at any time, involuntarily place the resident in a setting where he or she loses the entitlement to Medicaid. The resident may elect to be placed in a setting where he or she does not retain entitlement to Medicaid. Of course, if the resident, or the resident's guardian, voluntarily chooses to move to a setting—for example, back home with his or her family—that causes the resident's countable income or resources to exceed the State's eligibility standards, then the resident's Medicaid eligibility would be subject to termination under the same terms and procedures as applicable to all Medicaid beneficiaries.

A reduction plan must specify the actions that will be taken to protect the health and safety of the residents who remain in the affected facility while the reduction plan is in effect. The conferees

wish to avoid a situation in which a State, rather than correct the deficiencies in a facility within 6 months, attempts to use the reduction plan option to delay making needed improvements for an additional 3 years. The reduction plan is intended as an alternative compliance mechanism, not a tool for avoiding compliance. The conferees expect that, before approving any reduction plan, the Secretary will satisfy himself that the health and safety of the residents remaining in the facility will be assured during the entire phase-out period.

In this connection, a reduction plan must also provide that the ratio of qualified staff to residents at the affected facility (or part thereof) will be the higher of (1) the ratio which the Secretary determines is necessary in order to assure the health and safety of the remaining residents, or (2) the ratio which was in effect at the time that the Secretary made the finding of substantial deficiencies. A State may use temporary staff to satisfy these staffing ratio requirements, but only if the staff are qualified for the patient treatment responsibilities that they are assigned.

Finally, a reduction plan must provide for the protection of the interests of employees affected by the reduction plan, including (1) arrangements to preserve employee rights and benefits; (2) training and retraining of such employees where necessary; (3) redeployment of such employees to community settings under the reduction plan; and (4) making maximum efforts to guarantee the employment of such employees. This requirement is not to be construed to guarantee the employment of any employee.

Substantial failure to meet any of these reduction plan requirements subjects the State to one of two sanctions; termination of the facility provider agreement, or disallowance of Federal Medicaid matching payments equal to 5 percent of the cost of care for all eligible individuals in the facility for each month of noncompliance. The Secretary has discretion as to which sanction to apply, but must apply one or the other. The conferees expect that the Secretary will vigorously enforce these requirements for the protection of the resident population affected by a reduction plan.

Effective Date.—Enactment.

29. Annual Calculation of Federal Percentage (Section 9428)

Present law

Between October 1 and November 30 of each even-numbered year the Secretary of HHS is required to promulgate the Federal percentage that will be in effect for 2-year period beginning the following October. The Federal percentage is used to determine the Medicaid matching rate. Each State's AFDC program may use the Medicaid rate or a separate rate derived from the Federal percentage. The percentages are based on the average per capita income of each State and the United States for the three most recent calendar years for which satisfactory data are available from the Department of Commerce. The Federal percentage for the fiscal years 1986-1987 is based on State and national per capita income for calendar years 1981-1983.

House bill

No provision.

Senate amendment

Provides for annual, rather than biennial, calculation of the Federal percentage.

Conference agreement

The conference agreement follows the Senate amendment with a modification moving the effective date forward to fiscal year 1987. The conferees recognize that this modification will cause several States to receive substantially less in Federal Medicaid and AFDC matching payments than they otherwise would have received under current law for fiscal year 1987 only. However, the conferees expect that, over the long run, the greater sensitivity to State economic conditions will benefit all States. A "hold harmless" provision was considered by the conferees, but its estimated cost of \$155 million precluded its adoption. The conferees agree that the committees of jurisdiction will explore ways to relieve the hardship that may be suffered by the States that will receive substantially less in matching payments as a result of this provision.

30. Medicaid for Children Whose Adoption is Federally Aided (Section 9429)

Present law

The law extends Medicaid coverage to AFDC- or SSI-eligible children with special needs for whom Title IV-E adoption assistance payments are made. The State which entered into the adoption assistance agreement is responsible for providing Medicaid coverage to the child, even if the child and adoptive parents live in a different State. Similarly, children in foster care for which Federal funding is provided under Title IV-E are eligible for Medicaid coverage. The Medicaid coverage is provided by the State responsible for the foster care placement.

House bill

Specifies that, for purposes of Medicaid eligibility determinations, children receiving adoption assistance or foster care payments under Title IV-E of the Social Security Act are considered to be residents of the State in which they are placed even if this is not the State making the IV-E payment.

Senate amendment

In the case of children receiving adoption assistance, makes the State of the child's residence responsible for providing Medicaid coverage, even if the adoption assistance agreement was entered into with a different State.

Conference agreement

The conference agreement follows both the House bill and the Senate amendment. The conference agreement also clarifies that children with special medical or rehabilitative needs who are receiving Medicaid and who are adopted by parents under a publicly-funded adoption program (other than a program funded under Title IV-E of the Social Security Act) are eligible for Medicaid regardless of the income and resource levels of the adoptive parents.

States could, at their option, extend Medicaid coverage to such children if (1) an adoption assistance agreement (other than one under Title IV-E) is in effect; (2) the child was eligible for Medicaid under the State's plan before the adoption assistance agreement was entered into; and (3) the responsible State agency has determined that, because of the child's special needs for medical or rehabilitative care, the child would be difficult to place with adoptive parents without Medicaid coverage.

With the respect to the second requirement, the States may use either Title IV-A methodologies and standards, or Title IV-E methodologies and standards, in determining Medicaid eligibility for this population. With respect to the third requirement, the conferees note that it is not necessary that the State Medicaid plan cover all of the services necessary to treat the child's special medical needs; the issue is simply whether, absent Medicaid coverage, the child would be difficult to place.

Effective Date.—The provision concerning residency is effective beginning with medical assistance furnished on or after the first calendar quarter that begins more than 90 days after the date of enactment. The provision relating to coverage of children with special needs who receive State adoption assistance applies to adoption assistance agreements entered into before, on, or after enactment.

31. Elimination of 2-Year Limit for Obligation of Funds Under Maternal and Child Health Block Grants.

Present law

Under the Maternal and Child Health (MCH) Services Block Grant, States must obligate a fiscal year's allotment prior to the close of the following fiscal year.

House bill

No provision.

Senate amendment

Would repeal the requirement that States obligate their MCH allotments within a 2-year time frame.

Conference agreement

The conference agreement does not include the Senate provision.

32. Children With Special Health Care Needs (Section 9527)

Present law

The Maternal and Child Health Services Block Grant provides funds to States to deliver services and care for children who are crippled or who are suffering from conditions leading to crippling.

House bill

No provision.

Senate amendment

Would change the term "crippled children" to "children with special health care needs" wherever the term "crippled children"

appears in Title V, the Maternal and Child Health Services Block Grant.

Conference agreement

The conference agreement follows the Senate amendment. The conferees have agreed to strike the words "crippled children" and "crippled children's services" from Title V of the Social Security Act and to substitute in their place "children with special health care needs" and "services for children with special health care needs." In so doing, the conferees have simply made technical changes in the statutory language which more appropriately describe the populations to be served under the Title V program. No substantive changes in the program are intended.

Effective Date.—Enactment.

TITLE IX

SUBTITLE C—TASK FORCE ON LONG TERM CARE HEALTH POLICIES
(SECTION 9601)

Present law

No comparable provision.

House bill

The House bill requires the Secretary of the Department of Health and Human Services to establish, in consultation with the National Association of Insurance Commissioners, an 18-member Task Force on Long Term Health Care Policies. It further requires that the Task Force develop guidelines for long term health care policies. Within eighteen months after its establishment, the Task Force is to report to the Secretary and to the Congress on both the guidelines it has developed and on recommendations for any additional activities it finds appropriate. The report is to be distributed to the States through a cooperative effort between the Secretary and the National Association of Insurance Commissioners. The Secretary is required to report annually to the Congress on various activities related to the guidelines.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with an amendment making changes in the statutory language, terminating the Task Force upon completion of its report, limiting the number of secretarial reports to two and clarifying that the recommendations do not preempt State law.

The conference agreement replaces "guidelines" with "recommendations" in each instance where it appears. In making this change, the Conferees wish to emphasize their intent that these recommendations be used only at the option of each State. Under the conference agreement, States are not required to consider, refer to, or otherwise use the recommendations of the Task Force if they do not think it appropriate to do so.

Special effective dates, as described above, are provided for the provisions of the conference agreement relating to PBGC premiums, the special processing rule for pending cases, the DOL plan asset regulations, and the studies authorized.

TITLE XII—INCOME SECURITY AND RELATED PROGRAMS

1. *Minor and Federal amendments*

(a) Demonstration Projects Involving the Disability Insurance Program (Section 760 of the Senate amendment)

Present law

The Social Security Disability Amendments of 1980 directed the Secretary of Health and Human Services to develop and carry out experiments and demonstration projects to test the advantages of various ways to facilitate and encourage the return to employment of individuals who would otherwise remain dependent on disability benefits. A key element in conducting these demonstration projects is the authority for the Secretary to waive requirements of the Social Security Act related to the subject matter of the projects. A provision of the 1980 amendments calling for a final report within 5 years of the enactment of that statute has been interpreted as terminating the Secretary's authority to make such waivers. Without this waiver authority the Secretary is unable to carry out demonstration projects that have not yet been implemented.

House bill

No provision.

Senate amendment

Extends the waiver authority for 5 years. The deadline for a final report on the OASDI projects is extended to June 9, 1990. Since this requirement is made applicable only to OASDI, the provision could be interpreted to grant a permanent extension of authority to waive the Supplemental Security Income program rules.

Effective date.—Requires a final report to Congress by June 9, 1990.

Outlay effect (in millions):

Fiscal years:	
1986	\$3
1987	5
1988	5
3-year total	13

Conference agreement

House recedes to the Senate amendment.

(b) Disability Advisory Council (Section 761 of the Senate amendment)

Present law

The Social Security Act requires an Advisory Council on Social Security to be appointed every 4 years, at the beginning of each Presidential term, and to report by January 1 of the second year after appointment. The disability amendments enacted in 1984 re-

quire that the Council to be appointed in 1985 make recommendations on the medical and vocational aspects of disability.

House bill

No provision.

Senate amendment

Establishes a special ad hoc Disability Advisory Council in lieu of the general council scheduled to be appointed in 1985. The ad hoc Council shall report to Congress by December 31, 1986.

Outlay effect.—None

Conference agreement

House recedes to the Senate amendment.

(c) Taxation of Social Security Benefits Received by Certain Citizens of Possessions of the United States (Section 762 of the Senate amendment)

Present law

Citizens of American Samoa are treated as non-resident aliens and are subject to withholding of taxes from their social security benefits at a 15-percent rate. Citizens of other U.S. territories are exempt from the withholding requirement.

House bill

No provision.

Senate amendment

Eliminates U.S. tax withholding on social security payments to citizens of American Samoa, to make it consistent with the tax treatment of citizens of other U.S. possessions.

Effective date.—Applies to benefits received after December 31, 1983, in taxable years ending after such date.

Revenue effect (in millions):

Fiscal years:

1986	—\$1
1987	—1
1988	—1
3-year total	—3

Conference agreement

House recedes to the Senate amendment.

(d) Application of Dependency Test to Adopted Great-Grandchildren for Purposes of Child's Insurance Benefit (Section 763 of the Senate amendment)

Present law

A grandchild (under age 18) of a social security beneficiary may be entitled to benefits if the child is adopted by and lives with the grandparent for at least 1 year before applying for benefits and received half his support from the beneficiary.

House bill

No provision.

Senate amendment

Extends the provision to great-grandchildren of the beneficiary.

Effective date.—Applies with respect to benefits for which an application is filed after the date of enactment.

Outlay effect.—None.

Conference agreement

House recedes to the Senate amendment.

(e) Elimination of Requirement for Publication of Revisions in Pre-1979 Benefit Table (Section 764 of the Senate amendment)

Present law

The Secretary is required to publish the pre-1977 Amendments table of benefit amounts as revised by each general benefit increase. (This table applies to those eligible for benefits in 1978 or earlier.)

House bill

No provision.

Senate amendment

Eliminates the requirements to publish the revised tables, but would not affect the revisions themselves.

Effective date.—The month after the month of enactment.

Outlay effect.—None.

Conference agreement

House recedes to the Senate amendment.

(f) Notification Formula Clarification (Section 765 of the Senate amendment)

Present law

Under the 1983 Amendments, the Board of Trustees is required to notify Congress whenever it determines that the reserves in any of the trust funds at the beginning of any calendar year may become less than 20 percent of expenditures

House bill

No provision.

Senate amendment

Clarifies the Congressional intent that the determination should utilize a measure of reserves which includes the taxes credited to the trust funds on the first day of each month.

Effective date.—The month after the month of enactment.

Outlay effect.—None.

Conference agreement

House recedes to the Senate amendment.

(g) Extension of 15-month Reentitlement Period to Childhood Disability Beneficiaries Subsequently Entitled (Section 766 of the Senate amendment)

Present law

Disabled individuals who complete a 9-month trial work period and still have a disabling impairment, may be automatically reinstated to active benefit status during the next 15 months for any month in which their earnings fall below substantial gainful activity (SGA) level, currently \$300 per month. However, a person entitled to benefits as a disabled adult child who has used this provision once cannot subsequently be covered by it again.

House bill

No provision.

Senate amendment

Extends the subsequent 15-month reentitlement periods to reentitled childhood disability beneficiaries.

Effective date.—Applies to individuals who are disabled on or after December 1, 1980.

Outlay effect.—None.

Conference agreement

House recedes to the Senate amendment.

(h) Charging of Work Deductions Against Auxiliary Benefits in Disability Cases (Section 767 of the Senate amendment)

Present law

When a person receiving auxiliary benefits on the record of a disabled worker has earnings which exceed the exempt amount allowed under the earnings test, work deductions are imposed against the auxiliary worker's benefits which could be payable after any reduction for the family maximum limit. However, the amount withheld from the working individual is redistributed to others in the family so that the family continues to receive benefits up to the family maximum. As a result of a technical error in the 1980 amendments, this provision uses the regular (retired) family maximum formula for computing the amount to be withheld from the working family member instead of the disability family maximum formula which is used to determine the amount actually payable to the entire family.

House bill

No provision.

Senate amendment

Requires the use of the disability family maximum limit for computing the individual's deductions as well as for computing the total family entitlement.

Effective date.—Effective with respect to benefits payable for months after December 1985.

Outlay effect.—None.

Conference agreement

House recedes to the Senate amendment.

(i) Perfecting Amendments to Disability Offset Provision (Section 768 of the Senate amendment)

Present law

The 1981 Omnibus Budget Reconciliation Act expanded the social security disability offset (reduction in social security disability benefits due to receipt of other types of benefits) to include most governmental disability benefits paid to individuals. Previously, the offset was applicable only to workers' compensation payments. However, unclear wording led to confusion with regard to the continued application of the offset to certain workers' compensation benefits. Present law also treats State and local disability payments differently than similar Federal payments.

House bill

No provision.

Senate amendment

(a) Clarifies that all disability benefits paid under a Federal or State workers' compensation law or plan would continue to be subject to the disability offset.

(b) Clarifies that both Federal and State or local workers must have had substantially all their service covered by social security to be excluded from the disability offset.

Effective date.—(a) is effective as if it were in effect upon implementation of the Omnibus Budget Reconciliation Act of 1981. (b) is effective for persons becoming disabled after the month of enactment.

Outlay effect (in millions):

Fiscal years:	
1986	(*)
1987	—\$1
1988	—1
3-year total	—2

*Less than —\$500,000.

Conference agreement

House recedes to the Senate amendment.

(j) State Coverage Agreements (Section 769 of the Senate amendment)

Present law

Coverage of State and local employees under social security is, in most cases, effective on the date that an agreement is mailed by the State to the Secretary of Health and Human Services. However, for workers paid on a fee basis and for those whose coverage is retroactive, the agreement becomes effective on the date it is signed by both parties, which may result in complications and loss of coverage for some employees.

House bill

No provision.

Senate amendment

Makes all agreements and modifications of agreements effective on the date the agreement is mailed or delivered by other means to the Secretary.

Effective date.—For agreements or modifications mailed or delivered on or after the date of enactment.

Outlay effect.—None.

Conference agreement

House recedes to the Senate amendment.

(k) Effect of Early Delivery of Benefit Checks (Section 769A of the Senate amendment)

Present law

When the normal delivery date for social security benefits (the third day of the month) falls on a Saturday, Sunday or legal holiday, checks must be delivered on the nearest preceding banking day. This may result in checks being delivered in the previous month. If this situation arises at the end of a year, it could cause distortion of year-end trust fund balances, possibly making them low enough to trigger the stabilizer provision, which could effect the amount of cost-of-living increases. This could also result in exaggerated beneficiary tax liability in the earlier year and reduced tax liability in the later year.

House bill

No provision.

Senate amendment

Eliminates these problems by providing that, for purposes of asset-expenditure ratio calculations and taxation of benefits, Social Security benefits delivered prior to their scheduled delivery date would be deemed to have been paid on the regular delivery date.

Effective date.—For benefit checks issued for months ending after the date of enactment.

Outlay effect.—None.

Conference agreement

House recedes to the Senate amendment.

2. *Exemption from Social Security coverage for retired Federal judges on active duty (Section 769C of the Senate amendment)*

Present law

The 1983 Social Security Amendments (Public Law 98-21) provided that the wages of all active Federal judges would be subject to Social Security taxes beginning January 1, 1984. This provision applied to both current and future judges. P.L. 98-21 also specifically provided that amounts received by judges who achieve senior (retired) status but who continue on active duty would be subject to Social Security taxes on so much of their pay as was attributable to periods when they were performing judicial services. Those earnings would also cause reductions in the judges' benefits under the

social security retirement test. (Subsequently, P.L. 98-118 delayed the effective date of this provision until January 1, 1986.)

House bill

No provision.

Senate amendment

Excludes, from the definition of wages for Social Security purposes, the amounts received by Federal judges who meet the criteria for retirement on salary (e.g., age 65 with 15 years of service or 70 with 10 of service), who retire, and who perform active duty. The effect of this exclusion would be to exempt their pay from Social Security taxes and to preclude it from being counted for Social Security earnings test purposes.

Effective date.—Effective for services performed after December 31, 1983.

Outlay effect.—None.

Conference agreement

House recedes to the Senate amendment.

3. Recovery of overpayments (Section 769D of the Senate amendment)

Present law

Under the Social Security Act, entitlement to Social Security benefits ends with the month before the month of death and eligibility for Supplemental Security Income (SSI) benefits ends with the month of death. Under current reclamation procedures, benefits erroneously paid to a deceased individual by means of direct deposit are recovered by the Department of the Treasury from the financial organization which accept the deposit. In most cases, the financial organization debits the account to which the amounts were finally credited. When an account is debited, the financial organization is required to provide concurrent notice to any individuals shown as owners.

House bill

No provision.

Senate amendment

Provides that when (1) a payment is made to a deceased individual by means of direct deposit; (2) such payment is credited by a financial organization to an account jointly owned by the deceased individual and another person; and (3) such other person is (a) entitled to a Social Security benefit based on the same wages and self-employment income as the deceased person for the month immediately preceding the month in which the deceased person died; or (b) such other person is the surviving spouse of the deceased person and was eligible for an SSI payment (or federally administered State supplement) as an eligible spouse (including either member of an eligible couple) in the month in which the deceased individual died; such payment shall be treated as an overpayment to the surviving individual.

Effective date.—Applies to deaths of which the Secretary of Health and Human Services is first notified on or after the date of enactment.

Outlay effect.—None.

Conference agreement

House recedes to the Senate amendment.

4. *Study of benefit formula notch (Section 769E of the Senate amendment)*

Present law

Some workers who reach age 62 in 1979 (or later) and have their Social Security benefits determined under the computation provisions included in the 1977 Social Security amendments can get significantly lower monthly benefits than similar workers who reach age 62 in 1978 (or earlier), have similar earnings histories, retire at the same age and have their benefits computed under the old system. This difference in benefit amounts is commonly referred to as the "notch."

Because benefits are generally lower under the new system than the old one, a transitional provision was included in the 1977 amendments to smooth the differences between benefits computed under the two systems in the early years of the new system. A worker who reaches age 62 in 1979–1983 gets a benefit figured under the transitional provision if the benefit is higher than the one figured under the new system. While the transitional provision lessens the extent of the benefit differential, it does not eliminate it.

House bill

No provision.

Senate amendment

Directs the Secretary of HHS to appoint a panel to study the Social Security "notch". The panel is to study the extent of the benefit differential known as the "notch", as well as the nature and desirability of actions for addressing this benefit differential. The report is to include estimates of the short- and long-range costs of such proposals. The panel's report will be submitted to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives by December 15, 1986.

Effective date.—On enactment.

Outlay effect.—None.

Conference agreement

Senate recedes to the House bill.

5. *Coverage of Connecticut State police (Section 769H of the Senate amendment)*

Present law

Under the Social Security Act, only States specifically listed in the Act may extend social security coverage to policemen who are

covered under other retirement programs. Connecticut is not listed. Listed States may only extend coverage in one of two ways: (1) by covering all current and future employees of the affected group; or (2) by covering all future employees and those current employees who desire coverage.

House bill

No provision.

Senate amendment

Allows Connecticut, if the Governor so requests, to cover State police hired on or after May 8, 1984 without conducting a referendum.

Effective date.—Applies to individuals hired on or after May 8, 1984 who are members of the Tier II plan of the Connecticut State Employee Retirement System, with respect to services performed after enactment of this Act.

Revenue effect (in millions):

Fiscal years:	
1986	(1)
1987	\$1
1988	1
3-year total	2

¹ Less than \$500,000.

Conference agreement

House recedes to the Senate amendment.

6. *Removal of comment prohibition by Social Security and Medicare actuaries relating to economic assumptions (Section 735 of Senate amendment) (See also item 54 in Part I Medicare provisions)*

Present law

Requires Board of Trustees annual report on the financial status of the Social Security trust funds (including the Medicare trust funds) to include an actuarial opinion certifying that the assumptions and cost estimates used in the report are reasonable. According to Section 154 of the Social Security Amendments of 1983 (P.L. 98-21), that certification may not refer to the economic assumptions underlying the Trustees' reports.

House bill

No provision.

Senate amendment

Eliminates the language of current law prohibiting Social Security and Medicare actuaries from commenting on the economic assumptions underlying the Trustees' reports.

Effective date.—Enactment.

Outlay effect.—None.

Conference agreement

House recedes to the Senate amendment.

7. *Restoration of trust fund investments (Section 769G of the Senate amendment) [Related measures are contained in House and Senate amendments to H.J. Res. 372]*

House bill

No provision.

Senate amendment

For Social Security Trust Funds and other retirement funds:

(a) Requires the Secretary of the Treasury, on the basis as if H.J.Res. 372 (as deemed passed by the House on August 1, 1985) had been enacted on August 1, 1985, to:

(1) immediately reissue securities redeemed on or after September 1, 1985 that would not have been redeemed;

(2) pay the interest that would have accrued but for "non-investment, redemptions, and disinvestments" on or after September 1, 1985;

(b) Requires the Secretary to pay to the trust funds the present value of the permanent interest loss resulting from limitations on the public debt from September 1, 1984 to September 1, 1985.

The determinations of interest loss for Social Security and Medicare would be made by the Secretary of the Treasury and the Commissioner of Social Security, and by the Secretary and Chairman of the Railroad Retirement Board for railroad retirement. All determinations would be certified by the Comptroller General, and also by the public members of the Board of Trustees with respect to Social Security and Medicare.

(c) Requires the Secretary to provide 15 days prior notice to Congress and to each member of the Board of Trustees of any planned action to disinvest or not invest trust fund assets due to debt limit constraints.

Effective date.—Immediately with respect to reissuance of trust fund holdings; by June 30, 1986 with respect to the payment of lost interest (with April 1, 1986 or earlier notice to Congress of any disagreements in making the interest determinations).

Outlay effect.—None.

Conference agreement

Senate recedes with amendment to restore the 1984 losses of the Civil Service Retirement trust funds.

Civil Service

On December 31, 1985, the Secretary of the Treasury shall pay to the Civil Service Retirement and Disability Fund, from amounts in the general fund of the Treasury not otherwise appropriated, an amount determined by the Secretary to be equal to the sum of—

(i) the excess of the amount of interest which would have been earned by such fund, during the period beginning with September 28, 1984 and ending with December 31, 1984 on all moneys transferred to such fund on September 28, 1984, if all such monies had been invested on September 28, 1984, over the amount of interest actually earned by such fund on such monies during such period;

(ii) interest that would have been earned on the amount described in clause (i) during the period starting with January 1, 1985 and ending with June 30, 1985;

(iii) the excess of the amount of interest which would have been earned by such fund, during the period beginning on January 1, 1985 and ending on June 30, 1985, on all monies transferred to such fund on September 28, 1984, if all such monies had been invested on September 28, 1984, over the amount of interest actually earned by such fund on such monies during such period; and

(iv) the interest that would have been earned on the amounts described in clauses (i), (ii) and (iii) during the period starting with July 1, 1985 and ending with December 31, 1985.

Military

On March 31, 1986, the Secretary of the Treasury shall pay to the Department of Defense Military Retirement Fund, from amounts in the general fund of the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary of Defense, to be sufficient to compensate such fund, to the maximum extent practicable, for losses arising from the inability to invest, on October 1, 1984, all monies transferred to such fund on such date.

SUBTITLE B—SSI PROGRAM

1. Amendments relating to State supplementation under the SSI program

Present law

When there is an increase in the Federal SSI benefit standard, States which supplement the Federal standard are required to "passthrough" the Federal increase by not decreasing State supplementary payments. States are allowed to meet this requirement under two different options. Under the payment level option, a State can meet the passthrough requirement by not reducing the State supplementary payment levels (the net State payment over and above the Federal payment) below those in effect in March, 1983 but with a reduction in State payment levels allowed after July, 1983 to provide only a cost-of-living increase instead of the full \$20 individual and \$30 couple increase in the Federal SSI supplementary payment levels below their December, 1976 levels. As an alternative to the payment level option, a State can meet the passthrough requirement by spending as much in total for State supplementary payments in the 12-month period following the Federal increase as the State spent in the previous 12-month period.

House bill

No provision.

Senate amendment

The passthrough requirement under the payment level option would be modified to allow a State to meet the passthrough requirement by using either the current law's 1983 payment level

base or the previous law's December, 1976 State supplementary payment level base but with a full passthrough of the July, 1983 \$20/\$30 increase. This would allow any State that has increased its State supplementary payment levels above those in effect in December, 1976 to reduce those levels (but not below those in effect in December, 1976). This change would be effective for months beginning after March, 1983.

Conference agreement

The Conference agreement follows the Senate bill but with the following modifications. In addition to the current methods of compliance with the passthrough requirement, a State would be found to be in compliance with the passthrough requirement for calendar years 1984 and 1985 if in calendar year 1986, the State supplementary payment levels are such that, since December, 1976, the State has increased its State supplementary payment levels (other than for residents of medical facilities) by no less than the total percentage increase in the Federal SSI benefit standard between December, 1976 and February, 1986 including the cost-of-living increase for 1986.

The Conference agreement also provides that the Social Security Administration shall, at the request of a State, administer State supplementary payments provided to residents of medical institutions who are eligible for the \$25 a month Federal SSI personal needs allowance.

2. Third-party liability collections (SSI eligibility)

Present law

Medicaid recipients are required, as a condition of eligibility for Medicaid, to assign their rights to medical support payments and other payments for medical care to the State.

House bill

No provision.

Senate amendment

Requires applicants and recipients, as a condition of SSI eligibility, to cooperate with the Secretary of HHS in identifying and pursuing third parties liable for health coverage unless such individual has good cause for refusing to cooperate as determined in accordance with standards prescribed by the Secretary.

Conference agreement

The Conference agreement follows the House bill.

3. Preservation of benefit status for disabled widows and widowers who lost SSI benefits because of 1983 changes in actuarial reduction formula

Present law

The Social Security Amendments of 1983 raised the amount of benefits for disabled widows and widowers aged 50 to 59, effective January 1984. As a result of the increase, some beneficiaries lost

eligibility for Supplemental Security Income (SSI) and, consequently, Medicaid.

House bill

No provision.

Senate amendment

Requires that those low-income widows and widowers who lost SSI eligibility because of the January 1984 disability benefit increase may file an application for protection with the State within 15 months after enactment and be deemed to be receiving SSI benefits for the purpose of Medicaid eligibility. The provision further directs the Secretary to inform the States of the identities of affected individuals, solicit their applications for Medicaid coverage and process their applications promptly. Effective for months starting at least 2 months after enactment.

Conference agreement

The conference agreement follows the Senate bill.

Part VI: AFDC, Adoption Assistance, and Foster Care

1. AFDC and Medicaid quality control

(Section 301 of House bill)

Present law

AFDC: Federal regulations outline AFDC quality control procedures for measuring errors in eligibility and payment, identifying causes of error, and taking corrective action. A State's error rate is determined annually from the State's full sample and a Federal subsample.

Before enactment of P.L. 97-248, regulations required States to reach a 4 percent AFDC error tolerance level, in phased stages between fiscal years 1981 and 1984. Starting in FY 1984, the law reduced the tolerance level to 3 percent for erroneous excess payments (overpayments to eligibles and payments to ineligibles).

The law prescribes fiscal sanctions (withholding of some program matching funds) for State AFDC payment error rates that exceed tolerances. Fiscal sanctions have been assessed, but not collected. By regulation, the payment error rate tolerance is 4 percent for Puerto Rico, Guam, and the Virgin Islands. The statute allows fiscal incentives to be paid to those jurisdictions for dollar error rates (including underpayments) that are below 4 percent.

The law permits the HHS Secretary to waive all or part of fiscal sanctions if a State is unable to reach the target despite a good faith effort. This finding is limited to extraordinary circumstances.

Medicaid: Federal regulations require States to operate a Medicaid quality control eligibility system that identifies, on a sample basis, erroneous payments resulting from ineligibility, incorrect beneficiary liability, or third-party liability. States are required to take action to correct any eligibility, third-party liability, or other errors found in the sample cases. A State's error rate is determined annually from a State's full sample and a Federal subsample.

Effective with calendar quarters beginning April 1, 1983, P.L. 97-248 required States to keep their Medicaid payment error rates at or below 3 percent. Payment errors are Medicaid payments made for individuals or families in the sample subject to quality control review who were ineligible or who had not met beneficiary liability requirements prior to receiving services.

Technical errors that do not affect the amount of medical assistance paid are excluded from the calculation of a State's erroneous payments. Payments made on behalf of aged, blind or disabled individuals whose eligibility determinations were made exclusively by the Social Security Administration are excluded from the calculation of a State's erroneous payments.

States with Medicaid payment error rates in excess of 3 percent are subject to a disallowance of Federal Medicaid matching funds. These reductions are imposed prospectively, using an anticipated error rate projected by the Health Care Financing Administration (HCFA) based upon a State's previous error rates. At the end of each annual period, when actual payment error rates have been determined, the appropriate adjustment in Federal matching payments is made. Fiscal sanctions have been assessed and collected.

Puerto Rico, Guam, the Virgin Islands and American Samoa are not subject to a Medicaid payment error rate standard.

The Administrator of HCFA is authorized to waive all or part of the fiscal sanctions if the State is unable to meet the 3 percent standard despite a good faith effort. This finding is limited to extraordinary circumstances.

House bill

AFDC: Establishes basic AFDC quality control procedures in law. Permits States to use 6-month or annual samples, but not to reduce sample size.

Sets a national tolerance level of 3.5 percent for erroneous AFDC payments (payments to ineligible and overpayments to eligibles). Requires individual tolerance rates for States, which can range as high as 5 percent depending on the existence of the AFDC-UP program in the State, the share of earners among the State's AFDC families and the State's population density.

Revises calculation of a State's error rate by: excluding technical errors that do not affect the AFDC payment levels and by setting a State's error rate at the lower bound rather than the midpoint of the range within which its true error rate falls in cases where the sample size is sufficient to produce a lower bound that is no more than 2.5 percentage points below the midpoint.

Sets a State's fiscal sanction equal to the Federal portion of AFDC benefits paid above the State tolerance level, using the adjusted State error rate. Reduces a State's sanction by the Federal share of overpayments collected by the State in the fiscal year to which the sanction applies.

Requires the HHS Secretary to take into account factors beyond the State's control and other matters in replying to waiver requests. Requires the Secretary to waive fiscal sanctions if a State submits a corrective action plan that would increase its administrative costs by as much as 50 percent of the sanction. These expenditures would be a Federally-matched administrative expense.

Bill provisions would not apply to Puerto Rico, Guam and the Virgin Islands.

The legislation would be effective for quarters in fiscal 1983 and later, except at State option and in accordance with regulations to be prescribed by the HHS secretary, changes may take effect for quarters in FY 1981 and 1982, or in FY 1982.

Medicaid: No provision.

Senate amendment

AFDC and Medicaid: Prohibits collection of AFDC or Medicaid fiscal sanctions, including any as yet uncollected sanctions for 1981 and later years, for 2 years after enactment. Requires sanctions for the 2-year moratorium period and for earlier times to be subsequently calculated on the basis of rules in the restructured program.

During the 2-year moratorium of fiscal sanctions, continues data collection and calculation of error rates as under current law.

Requires the HHS Secretary to conduct a study of quality control systems for AFDC and Medicaid, examining how best to operate them to improve administration and obtain reasonable data on which to base fiscal sanctions. Requires the Secretary to contract with the National Academy of Sciences to conduct a concurrent study. Sets one year after enactment as the deadline for reports on both studies.

Requires the Secretary, not later than 18 months after enactment, to publish regulations to restructure the quality control systems for AFDC and Medicaid to the extent he determines appropriate and to establish criteria for adjusting fiscal sanctions calculated for quarters before the new systems so as to eliminate penalties that would not have been imposed had the new rules been in effect then. Requires the Secretary to take into account the prescribed quality control studies in revising the systems. Requires the Secretary to implement the revised systems beginning with the first calendar year after the two-year moratorium.

The provision would be effective on the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment.

2. Grants for teenage pregnancy program

(Section 302 of House bill)

Present law

Although some States operate pilot pregnancy service programs for teenage families, there is no specific block grant program designed to provide these services to AFDC recipients in each State.

House bill

Authorizes \$50 million in fiscal year 1986 and \$100 million in 1987 for grants to State AFDC agencies to operate teenage pregnancy programs for children and young parents up to age 25 who are eligible for AFDC. Limits funds to areas with high rates of teenage pregnancy or infant mortality. Requires each site receiving

funds to act to discourage teenage pregnancy and to give services to teenage mothers and fathers.

Goals of pregnancy prevention program include: encouraging children to postpone sexual activity and child bearing and to develop education and employment goals; identifying factors that determine teenage contraceptive use and sexual activity.

Makes eligible for services to help them become self-sufficient: AFDC-eligible persons under age 25 who are pregnant or are parents of children under 6 and who have not completed high school (or its equivalent) and who volunteer for the program. Requires participants to seek a high school diploma (or equivalent). Requires State programs to provide each participant with academic or vocational training, job counseling, employment readiness and job placement services, and an individualized assessment and plan. Provides that States could obtain permission from the Secretary to require participation if funds are sufficient to provide all necessary services for all eligible persons.

Prohibits use of these grant funds for abortions or counseling to have an abortion except when the mother's life would be endangered if the fetus were carried to term.

Allocates funds to States on the basis of their share of national AFDC benefit spending. Provides that unused funds would be reallocated where needed.

Requires applicant States to submit a program plan with provision for specified services. Requires participating States to report on program activities by March 1, 1987.

Requires the HHS Secretary to report to Congress on program evaluation and recommendations for the future by July 1, 1987.

Specifies that payments made and services given to program participants shall not be considered income or resources by AFDC.

The program would be effective from October 1, 1985 until September 30, 1987. (However, funds allocated to States before September 30, 1987 could be carried over to fiscal year 1988.)

Senate amendment

No provision.

Conference agreement

The conference agreement follows the Senate amendment.

3. AFDC for families with unemployed parents

(Section 303 of House bill)

Present law

States have the option to provide AFDC to financially eligible two-parent families in which the principal earner is "unemployed," defined as working fewer than 100 hours per month.

For eligibility, the law requires that the unemployed parent have worked 6 or more quarters in any 13-calendar quarter period ending within 1 year before applying for AFDC-UP.

States without an AFDC-UP program are: Alabama, Alaska, Arizona, Arkansas, Colorado, Florida, Georgia, Idaho, Indiana, Kentucky, Louisiana, Mississippi, Nevada, New Hampshire, New

Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, and Wyoming.

House bill

Requires all State AFDC programs to offer coverage to financially eligible two-parent families in which the principal earner is "unemployed," defined as working fewer than 100 hours per month.

Permits States to substitute for 4 of the 6 quarters of work, quarters of full-time attendance in elementary or secondary school or full-time participation in vocational training, but sets a lifetime limit of 4 quarters creditable to vocational training.

The provision would be effective October 1, 1986.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with an amendment establishing January 1, 1988 as the effective date for the mandate.

4. Recovery of excess funding for incomplete automated AFDC systems

(Section 771 of Senate amendment)

Present law

A Federal matching rate of 90 percent is paid for the development and installation of automated claims processing and information retrieval systems for AFDC. Systems must be designed and developed in accordance with a planning document approved by the Secretary of Health and Human Services.

House bill

No provision.

Senate amendment

Requires the Secretary to recover 40 percent of the amounts spent on automated systems from any State that fails to implement those systems by the implementation date called for in the approved planning document. Authorizes the HHS Secretary to extend the deadline if the failure to meet the deadline occurs for reasons which the State cannot control. The provision would be effective on the date of enactment, but applicable only to funds spent after that date.

Conference agreement

The House recedes. The managers intend that the Secretary of Health and Human Services extend any deadlines and waive any penalty if the deadline is not met for reasons which the State cannot control. Specifically, this would include extending the deadline for contractor delays and delays in hardware delivery which cause implementation delays. The conferees also recognize that the

deadlines set in the advanced planning document are established very early in the system development process. Frequently, these deadlines are unrealistic given the system design that is eventually chosen. States should be permitted to revise these deadlines, subject to the approval of the Secretary.

5. Counting certain payments to Indians as income

(Section 772 of Senate amendment)

Present law

A 1973 law, as amended in 1982, generally exempts from taxation certain per capita distributions to Indian tribal members from Indian trust funds and provides that such payments will be disregarded by Federally-funded benefit programs. As an exception to this rule, per capita payments in excess of \$2,000 can be counted as income for Federally-assisted programs other than those under the Social Security Act.

House bill

No provision.

Senate amendment

Applies the \$2,000 limit on uncounted income to Social Security Act programs. Calculates (for purposes of all Federally-assisted programs) the \$2,000 limit on the aggregate of all per capita payments received in a year by all members of a family unit. The amendment would be effective January 1, 1986.

Conference agreement

The Conference agreement generally follows the House bill. The Conference committee believes that there is need for a thorough review and evaluation of the current provisions of law concerning the manner in which various forms of per capita income received by members of Indian tribes and organizations is taken into account in determining the eligibility for and the amount of income and medical assistance under the Social Security Act and other federal programs.

Such an evaluation needs to take into account the unique responsibility that the Federal government has to members of Indian tribes and organizations. The evaluation also needs to consider how such responsibilities should fit within the broader Federal responsibilities to provide income and medical assistance to low income individuals and in an equitable manner irrespective of membership in a particular group or historical circumstances.

The Conferees, therefore, direct the General Accounting Office (GAO) to conduct a study of the extent, size, nature and frequency of payments to Indians from various funds which are based on their status as a member of an Indian tribe or organization. The study should also describe how these payments are treated under current law for purposes of eligibility for programs authorized under the Social Security Act and other means tested programs. As part of the study, the GAO would also gather information on the justification which has been given for special exceptions in the

counting of certain types of income received by members of Indian tribes or organizations.

It is intended that the report would be submitted to the Finance Committee and Agriculture Committee and Select Committee on Indian Affairs of the Senate and the Committee on Ways and Means, Committee on Energy and Commerce, Committee on Agriculture, Committee on Interior and Insular Affairs of the House. The report shall be submitted no later than one year from the date of enactment of this Conference Report.

6. Third-party liability collections (AFDC eligibility)

(Section 746 of Senate amendment)

Present law

Medicaid recipients are required, as a condition of eligibility for Medicaid, to assign their rights to medical support payments and other payments for medical care to the State.

House bill

No provision.

Senate amendment

Requires applicants and recipients, as a condition of AFDC eligibility, to cooperate with the Secretary of HHS in identifying and pursuing third parties liable for health coverage unless such individual has good cause for refusing to cooperate as determined by the State agency in accordance with standards prescribed by the Secretary. The provision would be effective for calendar quarters beginning on or after October 1, 1985, except delay is permitted where State legislation is required.

Conference agreement

The conference agreement follows the Senate amendment with a modification clarifying that individuals are required to identify, to the extent they are able, potentially liable insurers and other third parties, and to provide information to assist the State in pursuing third parties. Beneficiaries are not required to pursue the collections themselves. Pursuit is the responsibility of the provider or the State.

The Managers also note that, under current law, State child support enforcement agencies, which are required to enforce the child support obligations on behalf of all AFDC families, must also petition the court for medical support when it is available to the absent parent at a reasonable cost.

The conference agreement also follows the Senate amendment provision which excludes, from the calculation of AFDC fiscal sanctions, errors resulting from the application of this policy.

Part 1—Foster Care and Adoption Assistance

7. *Provisions relating to Medicaid coverage under the adoption assistance and Foster Care Programs*

(a) Medicaid Eligibility Related to Adoption Assistance Agreements

Present law

Under the Title IV-E adoption assistance program, only children for whom adoption assistance payment are being made under an Adoption Assistance Agreement are deemed to be receiving AFDC and thus eligible for Medicaid.

House bill

No provision.

Senate amendment

Removes the need for an actual adoption assistance payment to be made for the adopted child to be deemed eligible for Medicaid. If an Adoption Assistance Agreement under Title IV-E is in effect, the child would be deemed eligible for Medicaid. Applies to medical assistance furnished on or after the first calendar quarter that begins more than 90 days after the date of enactment.

Conference agreement

The Conference agreement follows the Senate amendment

(b) Medicaid Eligibility in State of Residence

Present law

The State which entered into the Adoption Assistance Agreement related to a particular child is responsible for providing Medicaid coverage to that child, even if the child and adoptive parents live in a different State. Similarly, for children in foster care the Medicaid coverage is provided by the State responsible for the foster care placement.

House bill

Amends Title XIX to specify that, for purposes of Medicaid eligibility, children receiving adoption assistance or foster care payments under Title IV-E of the Social Security Act are eligible for Medicaid from the State in which they reside even if this is not the State making the Title IV-E foster care or adoption assistance payment.

Senate amendment

Amends the Title IV-E adoption assistance law to provide that in the case of a child for whom an Adoption Assistance Agreement is in effect under Title IV-E, the State of the child's residence would be responsible for providing Medicaid to the child.

Conference agreement

The Conference agreement follows both the House bill and Senate amendment with modifications. The agreement provides that for purposes of Medicaid eligibility, children with respect to

whom there is an Adoption Assistance Agreement in effect under Title IV-E and foster care children for whom payments are being made under Title IV-E would be eligible for Medicaid from the State in which the child resides. The Conference agreement would amend both the Title XIX Medicaid statute and the Title IV-E adoption assistance and foster care program statute to provide for Medicaid eligibility in the State in which the child resides.

The provision is effective beginning with medical assistance furnished on or after the first calendar quarter that begins more than 90 days after the date of enactment.

(c) Medicaid Eligibility for Children Prior to Decree of Adoption

Present law

Adoption assistance and, therefore, Medicaid—to the extent that it is based on adoption assistance—are available only after a child is placed for adoption and an interlocutory decree of adoption is issued or the adoption is finalized under a judicial order.

House bill

No provision.

Senate amendment

Establishes Medicaid eligibility at the time a child is placed for adoption in accordance with applicable State law and for whom an adoption assistance agreement is in effect whether or not an interlocutory decree of adoption or a judicial decree of adoption has been issued. The amendment would apply to medical assistance furnished on or after the first calendar quarter that begins more than 90 days after the date of enactment.

Conference agreement

The Conference agreement follows the Senate amendment.

8. *Extension of ceiling on AFDC foster care funds and of State authority to transfer funds to child welfare services*

Present law

State-by-State ceilings on Federal AFDC foster care maintenance funds were imposed through fiscal year 1985 by Public Law 96-272, as amended, for any year in which Congress appropriated a specified sum of Title IV-B child welfare funds. Each State's ceiling was based on funding for previous years or the State's under-18 population. The mandatory ceilings were not in effect in fiscal years 1983-85 because child welfare funds remained below the trigger level (\$266 million). However, many States chose to operate under a voluntary ceiling.

The law provided that through fiscal year 1985, when operating under a foster care funding limit, whether mandatory or voluntary, and under certain conditions, States could transfer at least some of their allocation of unused foster care funds to child welfare services (all unused foster care funds if a mandatory ceiling were in effect).

House bill

No provision.

Senate amendment

Extends through fiscal year 1987 the ceilings on AFDC foster care funds when annual child welfare services appropriations equal at least \$266 million. Extends formulas for calculating each State's ceiling and provisions allowing States to transfer unused foster care funds to child welfare services through fiscal year 1987. Effective October 1, 1985.

Conference agreement

The Conference agreement follows the Senate amendment.

9. Extension of authority for AFDC foster care payments on behalf of children placed in foster care under a voluntary placement agreement

Present law

Title IV-E AFDC foster care payments were authorized through fiscal year 1985 by P.L. 96-272, as amended, for children removed from their home under a voluntary placement agreement, provided States met specified protections and procedures.

House bill

No provision.

Senate amendment

Extends through fiscal year 1987 provisions allowing payments for children placed in foster care under a voluntary agreement. Effective October 1, 1985.

Conference agreement

The Conference agreement follows the Senate amendment.

10. Independent living initiatives

Present law

AFDC foster care maintenance payments are intended for such essentials as food and shelter and generally end when the child reaches age 18 (although some States continue aid to high school students under age 19). Specific services to help foster children prepare for independent living as adults must be funded either by the State or by other Federal programs, such as the Title XX block grant or Title IV-B child welfare services.

House bill

No provision.

Senate amendment

Authorizes \$45 million each for fiscal years 1987 and 1988 for State entitlement programs to help AFDC foster care children age 16 and over prepare for independent living. Each State's share of funds would equal its proportion of the fiscal year 1984 AFDC

foster care caseload. Provides that any unused funds would be reallocated to States needing them. Requires no State matching funds, but stipulates that program funds shall not replace those already available for the same general purpose.

Cites as examples of services that would promote the program's objective: enabling children to complete high school or receive vocational training; providing training in daily living skills such as budgeting and career planning; counseling; coordinating services; outreach activities; and developing individuals plans for the transition to independent living. The services will be provided directly by the State agency or under contracts with local governmental entities or private nonprofit organizations that have children in their care.

Requires State case plans for Title IV-E foster care children, where appropriate, to include a description of programs and services that will help them prepare for independent living.

Requires States to submit a report by March 1, 1988, on the uses of program funds and the attainment of program goals. Requires the DHHS Secretary to submit to Congress by July 1, 1988, a description and evaluation of the program and recommendations for the future. The effective date except as noted, would be upon enactment.

Conference agreement

The Conference agreement follows the Senate amendment.

SUBTITLE D—UNEMPLOYMENT COMPENSATION

1. Supplemental unemployment compensation for certain individuals

Present law

The Federal Supplemental Compensation program (FSC), which provided additional weeks of unemployment compensation to individuals who had exhausted their regular State benefits, was due to expire on April 6, 1985. Public Law 99-15, enacted on April 4, 1985, allowed individuals who were receiving FSC benefits for the week of March 31-April 6, to continue to receive the remainder of their benefits. No new FSC benefits were payable after April 6, 1985. Under Public Law 99-15, the remaining weeks of FSC benefits had to be collected in consecutive weeks of unemployment. Any interruption of benefits, for whatever reason, ended an individual's eligibility for FSC benefits.

House bill

The bill allows certain individuals in the State of Pennsylvania to collect the remainder of their FSC benefits, notwithstanding the requirement in Public Law 99-15 that such benefits be collected in consecutive weeks. These individuals were receiving FSC for the week of March 31, 1985-April 6, 1985, and were eligible to collect the remainder of their benefits under Public Law 99-15. The collection of their remaining benefits was interrupted, however, when they were called up in the National Guard in early June to provide services during a major disaster.

The provision applies only to individuals who were called up for National Guard duty by the Governor in a disaster declared by the President on June 3. It applies to weeks of unemployment occurring after the individual had completed his Guard duty but during which he may not have met the work search or availability requirements of State law because he failed to file claims believing he was no longer eligible (having failed to file in consecutive weeks). It applies only until an individual's FSC benefits were exhausted or he became employed, whichever occurred earlier.

Effective date.—For weeks of unemployment beginning after March 31, 1985.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

2. Recovery of overpayments

Present law

When a State finds that it has made an overpayment of unemployment benefits, it may (after observing appropriate procedural safeguards) collect that overpayment by withholding a subsequent unemployment benefit due to the same individual.

This procedure, however, is permitted only when both the incorrect payment and the withheld payment are funded from the State's own unemployment trust fund. In some circumstances, unemployed workers receive benefits which are paid by the same State agency and appear to the worker as though they were the same type of unemployment benefit but are funded from different sources. This can occur, for example, when a worker moves from one State to another and receives some benefits from the State from which he moved. It also happens when a worker's entitlement is extended by reason of trade adjustment assistance or other Federally-financed unemployment programs.

House bill

No provision.

Senate amendment

Allows reciprocal withholding of overpaid unemployment benefits regardless of the funding source. The same procedural safeguards would be required, but an overpayment of State benefits could be recovered by withholding from subsequent Federally-funded benefits if the State also agreed that it would recover incorrect Federal benefits. Similarly, States would be allowed to withhold benefits payable under their program to recover payments of benefits incorrectly made to the same individual by other States. Implementation of this provision would be at the option of each State.

Effective date.—October 1, 1985.

Conference agreement

The conference agreement follows the Senate amendment.

The House Conferees from the Committee on Energy and Commerce were appointed solely for the consideration of issues related to authorization of expenditures from the Superfund and took no part in the consideration of the Superfund revenue aspects of the Senate amendment.

TITLE XIII—TRADE, CUSTOMS, INCOME SECURITY, AND RELATED PROGRAMS

SUBTITLE A—TRADE AND CUSTOMS PROVISIONS

Part 1—Trade Adjustment Assistance

Short title (Section 13001 of Conference Agreement).

House bill

No provision.

Senate amendment

“Trade Adjustment Assistance Reform and Extension Act of 1985.”

Conference agreement

House recedes.

A. WORKER ADJUSTMENT ASSISTANCE

1. *Petitions (section 13002 of conference agreement; section 778A of Senate amendment)*

Present law

Section 221 permits any group of workers or their authorized representative to file a petition with the Secretary of Labor for a certification of eligibility to apply for TAA.

House bill

No provision.

Senate amendment

Provides explicitly that workers in agricultural firms or subdivisions may petition for TAA certification.

Effective date.—1 year after import fee imposed; i.e., 1 year after the earlier of 2 years after enactment or 30 days after the President certifies that the GATT allows such a fee.

Conference agreement

House recedes with an amendment to make the provision effective upon date of enactment.

the prior year any principal or interest from a loan after September 30, 1985 remains unpaid.

Effective date.—The tax provisions will apply to remuneration paid after June 30, 1986. The extension of borrowing authority is effective on enactment.

Senate amendment

The Senate amendment includes the same provisions on loan authority, loan repayment tax, and loan surtax as in the House bill.

In addition, under the Senate amendment a portion of the tier 2 railroad retirement tax equal to one percent of the payroll subject to that tax will be diverted from the railroad retirement program to the RRUI program. These revenues would then be returned to the railroad retirement program to help repay the principal and interest on loans made prior to October 1, 1985. This diversion provision will apply effective January 1, 1986 and will terminate on April 1, 1990.

Conference agreement

The conference agreement is the same as the House bill.

2. Extension of Medicare coverage, hospital insurance tax to State and local government employees

Present law

State and local government employees are covered for social security and Medicare benefits, and such employees and their employers are subject to the FICA tax (including the hospital insurance portion), only pursuant to voluntary agreement between the State and the Secretary of Health and Human Services (Code sec. 3121(b)(7)). Governmental units whose employees have such coverage pursuant to voluntary agreement may not later withdraw their employees from coverage.

Medicare coverage (and the corresponding hospital insurance payroll tax) is mandatory for Federal employees.

For wages paid after 1985, the employer-employee hospital insurance tax rate will be 2.9 percent of the first \$42,000 of wages (sec. 3101, 3111, and 3121(a)).

House bill

The House bill extends Medicare coverage on a mandatory basis to State and local government employees hired after December 31, 1985, for service performed after that date. These employees and their employers will be liable for the hospital insurance portion of the FICA tax.

Under the House bill, Medicare coverage and the hospital insurance tax are not extended to individuals hired by a State or political subdivision to relieve unemployment; patients or inmates working in a hospital, home, or other institution; temporary workers hired for certain emergencies; or certain students working in District of Columbia hospitals.

The House bill makes technical changes relating to payment of hospital insurance taxes and definition of Medicare-qualified government employment.

Senate amendment

The Senate amendment extends Medicare coverage on mandatory basis to all current and new State and local government employees, effective for service performed after September 30, 1986. These employees and their employers will be liable for the hospital insurance portion of the FICA tax. Under the Senate amendment, employees who perform State or local government service during and before October 1986 will be given credit toward Medicare eligibility for such past State or local government employment.

The Senate amendment provides that hospital insurance taxes for Medicare-qualified State or local government employment are to be collected in the same manner as in the case of such taxes paid by nongovernmental employers.

Conference agreement

The conference agreement follows the House bill, except that a State may extend Medicare coverage (without extending coverage under social security cash benefits) to State and local government employees hired prior to 1986 by voluntary agreement with the Secretary of Health and Human Services. Such employees and their employers would also be liable for the hospital insurance portion of the FICA tax. Under this provision, the collection of Medicare contributions for State and local government employees who are newly covered by this bill will be carried out by the State social security office in cases where the local jurisdiction (or State government) currently has in effect an agreement covering some employees of the jurisdiction under social security. Those jurisdictions (e.g., a city, county, or other government subdivision) within a State that have no employees currently covered under a section 218 agreement will be required to make their payments for Medicare coverage of their employees under the same procedures as private employers currently follow.

3. Tobacco excise tax provisions

a. Extension of present cigarette excise tax rates

Present law

A manufacturers' excise tax equal to \$8 per thousand is imposed on small cigarettes; this produces a tax of 16 cents on a pack of 20 cigarettes. Large cigarettes (those weighing more than 3 pounds per thousand) are taxed at \$16.80 per thousand. These tax rates are scheduled to decrease by one-half after December 19, 1985.

House bill

The House bill makes permanent the present cigarette excise tax rates (e.g., 16 cents per pack of 20 small cigarettes).

Senate amendment

The Senate amendment is the same as the House bill.

Conference agreement

The conference agreement follows the House bill and the Senate amendment.

December 3, 1985, care described in subclause (v) of section 601(4)(C) of title 38, United States Code, relating to the Administrator's authority to provide hospital care and medical services in certain noncontiguous "States" (defined in present section 101(20) to include United States Territories and possessions and the Commonwealth of Puerto Rico), including any waiver made by the Administrator of the applicability to the Commonwealth of Puerto Rico or the Virgin Islands of the restrictions described in that subclause for that period. This authority to provide such care and services also expired on October 31, 1985, but was made permanent in the case of the Virgin Islands, and was extended (with certain limitations) for an additional three years in the case of Puerto Rico, by section 102 of Public Law 99-166, enacted on December 3, 1985.

ALCOHOL AND DRUG TREATMENT AND REHABILITATION CONTRACT PROGRAM

The compromise agreement (section 19034(c)) also contains a provision ratifying any action taken by the Administrator of Veterans' Affairs in connection with entering into any contract to provide, during the period beginning November 1, 1985, and ending December 3, 1985, care described in section 620A of title 38, relating to contracts for certain care and treatment and rehabilitative services for eligible veterans suffering from alcohol or drug dependence or abuse disabilities. This authority to provide such care and services also expired on October 31, 1985, but was extended for an additional three years by section 101 of Public Law 99-166.

From the Committee on the Budget, for consideration of the entire Senate amendment and the entire House amendment to the Senate amendment, except for sections 778H, 778I, 780, 781, 783 through 789B, 789D through 789G, subpart A of part 3 of subtitle I of title VII, section 793, subsections (a), (b), (c), (f), and (g)(1) of section 794, and sections 795 and 796 of the Senate amendment, and except for sections 2502(a) and 2503 of division B of the House amendment to the Senate amendment:

WILLIAM H. GRAY III,
BUTLER DERRICK,
MICHAEL D. BARNES,
CHARLES E. SCHUMER,
BARBARA BOXER,
BUDDY MACKAY,
JIM SLATTERY,
CHESTER G. ATKINS,

From the Committee on Ways and Means, solely for the consideration of sections 144(b)(3), 204, 205, 746(e)(2)-(4), and 759, subtitles A, C-F, H, and I of title VII, part G of title IX, and part I of title IX of the Senate amendment, and of subtitles B and C of title III and section 1974 of division A, and all of division B except parts E and G of title I, of the House amendment to the Senate amendment:

SAM GIBBONS,
J.J. PICKLE,
CHARLES B. RANGEL,
JIM JONES,

HAROLD FORD,
ED JENKINS,
JOHN J. DUNCAN,
BILL GRADISON,
CARROLL CAMPBELL,
WM. THOMAS,

From the Committee on Agriculture, solely for the consideration of title I and section 536 of the Senate amendment:

E DE LA GARZA,
ED JONES,
LEON E. PANETTA,
TONY COELHO,
BERKLEY BEDELL,
ED MADIGAN,
ED EMERSON,
JAMES M. JEFFORDS,
E. THOMAS COLEMAN,

From the Committee on Agriculture, solely for the consideration of subpart B of part 3 of subtitle I of title VII of the Senate amendment:

E DE LA GARZA,
CHARLIE ROSE,
WALTER B. JONES,
CHARLES HATCHER,
CHARLIE WHITLEY,
ROBIN TALLON,
ROBERT L. THOMAS,
LARRY J. HOPKINS,
PAT ROBERTS,
WEBB FRANKLIN,
LARRY COMBEST,

From the Committee on Agriculture, solely for the consideration of subpart B of part 3 of subtitle I of title VII of the Senate amendment:

E. DE LA GARZA,
CHARLIE ROSE,
CHARLIE WHITLEY,
LARRY J. HOPKINS,
PAT ROBERTS,

From the Committee on Armed Services, solely for the consideration of title II and section 165 of the Senate amendment, and of title I of division A of the House amendment to the Senate amendment:

LES ASPIN,
G.V. MONTGOMERY,
PAT SCHROEDER,
WM. L. DICKINSON,
BUD HILLIS,

From the Committee on Banking, Finance and Urban Affairs, solely for the consideration of title III of the Senate amendment and of title II of division A of the House amendment to the Senate amendment:

FERNAND J. ST GERMAIN,
PARREN J. MITCHELL,

STAN LUNDINE,
 MARY ROSE OAKAR,
 BRUCE VENTO,
 BARNEY FRANK,
 CHALMERS P. WYLIE,
 STEWART MCKINNEY,
 MARGE ROUKEMA,
 STEVE BARTLETT,

From the Committee on Banking, Finance and Urban Affairs, solely for the consideration of subtitle A of title IV of division A of the House amendment to the Senate amendment:

FERNAND J. ST GERMAIN,
 STAN LUNDINE,

From the Committee on Education and Labor, solely for the consideration of parts A through E of title IX of the Senate amendment, and of subtitle A of title III of division A of the House amendment to the Senate amendment:

AUGUSTUS F. HAWKINS,
 WILLIAM D. FORD,
 MARIO BIAGGI,
 PAT WILLIAMS,
 MAJOR R. OWENS,
 CHARLES A. HAYES,
 CARL C. PERKINS,
 TERRY L. BRUCE,
 JIM JEFFORDS,
 E. THOMAS COLEMAN,
 STEVE GUNDERSON,
 PAUL B. HENRY,

From the Committee on Education and Labor, solely for the consideration of section 746(d), subtitle H of title VII, section 782, and parts G and I of title IX of the Senate amendment, and of subtitles B and C of title III of division A, and of sections 2181 and 2505 and title VI of division B, of the House amendment to the Senate amendment:

GUS HAWKINS,
 WILLIAM D. FORD,
 JOSEPH M. GAYDOS,
 WILLIAM CLAY,
 MARIO BIAGGI,
 DALE E. KILDEE,
 MAJOR R. OWENS,
 CHARLES A. HAYES,
 MERVYN M. DYMALLY,
 CHESTER G. ATKINS,
 JAMES M. JEFFORDS,
 THOMAS E. PETRI,
 MARGE ROUKEMA,
 STEVE BARTLETT,
 ROD CHANDLER,
 RICHARD ARMEY,
 HARRIS W. FAWELL,

From the Committee on Education and Labor, solely for the consideration of part F of title IX of the Senate amendment:

AUGUSTUS F. HAWKINS,
AUSTIN J. MURPHY,
BILL CLAY,
PAT WILLIAMS,
JIM JEFFORDS,
TOM PETRI,
STEVE BARTLETT,

From the Committee on Energy and Commerce, solely for the consideration of sections 706 and 713-716, parts 2-5 of subtitle A of title VII (except for section 734), subtitle B of title VII (except for subsections (d) and (e)(2)-(4) of section 746), sections 769B, 770, 772, 774, and 782, and parts G and H of title IX of the Senate amendment, and of section 1974 of division A, and of section 2107, parts B-G of title I, and section 2302 of division B of the House amendment to the Senate amendment:

JOHN D. DINGELL,
HENRY A. WAXMAN,
JAMES H. SCHEUER,
THOMAS LUKEN,
DOUG WALGREN,
BARBARA A. MIKULSKI,
MICKEY LELAND,
CARDISS COLLINS,
RON WYDEN,
ED MADIGAN

(for Medicaid and maternal
and child health only),

BOB WHITTAKER
(for Medicare, Medicaid, and
maternal and child health
only),

From the Committee on Energy and Commerce, solely for the consideration of those portions of section 789C of the Senate amendment inserting subsections 9505 (c), (d), and (e) in the Internal Revenue Code:

JOHN D. DINGELL,
DENNIS E. ECKART,
RALPH M. HALL,
BILLY TAUZIN,
WAYNE DOWDY,
TOM LUKEN,
AL SWIFT,
MIKE SYNAR,
NORMAN F. LENT,
DON RITTER,
JACK FIELDS,
DAN SCHAEFER,

From the Committee on Energy and Commerce, solely for the consideration of sections 501, 502, 521-524, and 536 of the Senate amendment, of subtitles A-E of title IV and subtitles B and C of title VIII of division A of the House amendment to the Senate amendment:

JOHN D. DINGELL,
PHIL SHARP,

ED MARKEY,
DOUG WALGREN,
AL SWIFT,
MICKEY LELAND
(except for strategic petroleum reserve, shared energy, biomass loan guarantee, and synfuels programs),

RICHARD C. SHELBY,
MIKE SYNAR,
BILLY TAUZIN,
JAMES T. BROYHILL,
BILL DANNEMEYER,
CARLOS MOORHEAD,
BOB WHITTAKER,
MICHAEL G. OXLEY,
FRED J. ECKERT,

From the Committee on Energy and Commerce, solely for the consideration of sections 403 and 404 of the Senate amendment, and subtitle F of title IV of division A of the House amendment to the Senate amendment:

JOHN D. DINGELL,
TIMOTHY E. WIRTH,
JAMES H. SCHEUER,
TOM LUKEN,
AL SWIFT,
MICKEY LELAND,
CARDISS COLLINS,
MIKE SYNAR,
BILLY TAUZIN,

From the Committee on Energy and Commerce, solely for the consideration of sections 401, 402, 408, 769G, 777(h)(1), and subsections (d), (e), (g)(2) and (g)(3) of section 794 of the Senate amendment, and of subtitles G and H of title IV of division A, and of sections 2252(b) and 2402 of division B of the House amendment to the Senate amendment:

JOHN D. DINGELL,
JAMES J. FLORIO,
PHIL SHARP,
BILLY TAUZIN,
RALPH M. HALL,
WAYNE DOWDY,
BILL RICHARDSON,
JIM SLATTERY,
JIM BROYHILL,
NORMAN F. LENT,
DON RITTER,
DAN COATS,
JACK FIELDS,

From the Committee on Government Operations, solely for the consideration of subtitle G of title VII of the Senate amendment:

JACK BROOKS,
DON FUQUA,

TED WEISS,
FRANK HORTON,
ROBERT S. WALKER,

From the Committee on Government Operations, solely for the consideration of section 523 and parts C and D of title VIII of the Senate amendment, and of subtitle E of title IV of division A of the House amendment to the Senate amendment:

JACK BROOKS,
DON FUQUA,
CARDISS COLLINS,
FRANK HORTON,
AL MCCANDLESS,

From the Committee on Interior and Insular Affairs, solely for the consideration of sections 521, 522, and 531-535 of the Senate amendment, and of subtitle C of title IV, section 1542, title V, subtitles D and H of title VI, and subtitle C of title VIII, of division A of the House amendment to the Senate amendment:

MO UDALL
(except for Outer Continental Shelf programs),

JOHN F. SEIBERLING
(except for Outer Continental Shelf programs),

JIM WEAVER
(except for Nuclear Regulatory Commission fees),

GEORGE MILLER,
PHIL SHARP
(except for Outer Continental Shelf programs),

NICK RAHALL,
BRUCE F. VENTO
(except for Outer Continental Shelf programs),

JERRY HUCKABY,
SAM GEJDENSON
(except for Outer Continental Shelf programs),

DON YOUNG
(except for Nuclear Regulatory Commission fees),

MANUEL LUJAN, Jr.
(except for Nuclear Regulatory Commission fees),

ROBERT J. LAGOMARSINO
(except for Outer Continental Shelf programs, and Nuclear Regulatory fees),

RON MARLENEE
(except for Outer Continental Shelf programs, and Nuclear Regulatory Commission fees),

CHARLES PASHAYAN, Jr.

(except for Nuclear Regulatory Commission fees),

From the Committee on the Judiciary, solely for the consideration of section 982 and that portion of section 999 amending paragraph (2) of section 4074(c) of the Employee Retirement Income Security Act, of the Senate amendment, and of that portion of section 1458 inserting section 4041(c)(2)(B)(ii) in the Employee Retirement Income Security Act, of division A, and section 2124(b) of division B, of the House amendment to the Senate amendment:

PETER W. RODINO, Jr.,
DANIEL GLICKMAN,
DON EDWARDS,
HAMILTON FISH, Jr.,
THOMAS N. KINDNESS,

From the Committee on Merchant Marine and Fisheries, solely for consideration of sections 405, 406, 407, and 531-535 of the Senate amendment, and of titles V and VI of division A of the House amendment to the Senate amendment:

WALTER B. JONES,
MARIO BIAGGI,
GLENN M. ANDERSON,
JOHN BREAUUX,
GERRY E. STUDDS,
BARBARA A. MIKULSKI,
MIKE LOWRY,
DOUGLAS H. BOSCO,

(In lieu of Mr. Hughes solely for consideration of sections 531-535 of the Senate amendment and title V and subtitles D and H of title VI of division A of the House amendment to the Senate amendment):

BILLY TAUZIN,
NORMAN F. LENT,
GENE SNYDER,
DON YOUNG
(except as listed below),
BOB DAVIS,

(In lieu of Mr. Young solely for consideration of sections 531-535 of the Senate amendment and title V and subtitles D and H of title VI of division A of the House amendment to the Senate amendment):

WILLIAM CARNEY,
JACK FIELDS
(for purposes of OCS programs only),

From the Committee on Post Office and Civil Service, solely for the consideration of section 769G and parts A and B of title VIII of the Senate amendment, and of title VII of division A of the House amendment to the Senate amendment:

WILLIAM D. FORD,
MICKEY LELAND,
MARY ROSE OAKAR,
GENE TAYLOR,
BENJAMIN A. GILMAN,

From the Committee on Public Works and Transportation, solely for the consideration of title VI, sections 777(h)(2) and 1202, and those portions of section 789C inserting sections 9505 (c), (d), and (e) in the Internal Revenue Code, of the Senate amendment, and of sections 1533, 1541, and title VIII of division A, and section 2252(c) of division B of the House amendment to the Senate amendment:

JAMES J. HOWARD

(except for Superfund authorization and pipeline programs),

GLENN M. ANDERSON

(except for Superfund authorization and pipeline programs),

ROBERT A. ROE

(except for Superfund authorization and pipeline programs),

NORMAN Y. MINETA

(except for Superfund authorization and pipeline programs),

JAMES L. OBERSTAR

(except Superfund authorization),

HENRY J. NOWAK

(except Superfund authorization and pipeline programs),

BOB EDGAR

(except Superfund authorization and pipeline programs),

ROBERT A. YOUNG

(except Superfund authorization and pipeline programs),

NICK RAHALL

(except Superfund authorization and pipeline programs),

GENE SNYDER

(except Superfund authorization and pipeline programs),

JOHN PAUL HAMMERSCHMIDT

(except Superfund authorization),

BUD SHUSTER

(except Superfund authorization and pipeline programs),

ARLAN STANGELAND

(except Superfund authorization),

NEWT GINGRICH

(except Superfund authorization and pipeline programs),

BILL CLINGER

(except Superfund authorization and pipeline programs),

(In lieu of Mr. Rahall solely for the consideration of section 1541 and subtitle B of title VIII of division A of the House amendment to the Senate amendment):

JOHN BREAUX,

From the Committee on Science and Technology, solely for the consideration of sections 406(a)-(c), (e)-(g), and (i) of the Senate amendment:

DON FUQUA,

JAMES H. SCHEUER,

TIM WIRTH,

MANUEL LUJAN, Jr.,

CLAUDINE SCHNEIDER,

From the Committee on Small Business, solely for the consideration of title X of the Senate amendment and of title IX of division A of the House amendment to the Senate amendment:

PARREN J. MITCHELL,

JOSEPH P. ADDABBO,

JOSEPH M. McDADE,

SILVIO O. CONTE,

From the Committee on Veterans' Affairs, solely for the consideration of section 205 and title XI of the Senate amendment, and of title X of division A of the House amendment to the Senate amendment:

G.V. MONTGOMERY,

BOB EDGAR

(solely for requirement of Medicare providers to accept VA beneficiaries),

DOUGLAS APPLGATE

(solely for requirement of Medicare providers to accept VA beneficiaries),

JOHN PAUL HAMMERSCHMIDT,

CHALMERS P. WYLIE,

Managers on the Part of the House.

From the Committee on Agriculture, Nutrition, and Forestry:

JESSE HELMS,

BOB DOLE,

RICHARD G. LUGAR,

THAD COCHRAN,

ED ZORINSKY,

PATRICK LEAHY,

JOHN MELCHER,

From the Committee on Finance—general conferees:

BOB PACKWOOD,
W.V. ROTH, Jr.,
J.C. DANFORTH,
JOHN H. CHAFEE,
RUSSELL B. LONG,
LLOYD BENTSEN,
SPARK M. MATSUNAGA,

From the Committee on Armed Services:

SAM NUNN,

From the Committee on Veterans' Affairs:

FRANK H. MURKOWSKI,
ALAN K. SIMPSON,
ALAN CRANSTON,

From the Committee on Finance—for CHAMPUS Medicare Sub-conference only:

DAVE DURENBERGER,
MAX BAUCUS,

From the Committee on Banking, Housing, and Urban Affairs:

JAKE GARN,
JOHN HEINZ,
CHIC HECHT,

From the Committee on Commerce, Science, and Transportation:

J.C. DANFORTH,
BOB PACKWOOD,
BARRY GOLDWATER,
LARRY PRESSLER,
SLADE GORTON,
TED STEVENS,
FRITZ HOLLINGS,
RUSSELL LONG,
DANIEL K. INOUE,
WENDELL FORD,
DON RIEGLE,

From the Committee on Energy and Natural Resources—general conferees:

JAMES A. McCLURE,
PETE V. DOMENICI,
MALCOLM WALLOP,
J. BENNETT JOHNSTON,
WENDELL H. FORD,

From the Committee on Energy and Natural Resources—conferees on title VI, section 6701 only:

JAMES A. McCLURE,
MARK O. HATFIELD,
PETE V. DOMENICI,
J. BENNETT JOHNSTON,
WENDELL H. FORD,

From the Committee on Commerce, Science, and Transportation—conferees on title VI, section 6701 only:

BOB PACKWOOD,
ERNEST F. HOLLINGS,
RUSSELL B. LONG,

From the Committee on Environment and Public Works:

ROBERT T. STAFFORD,
JOHN H. CHAFEE,
AL SIMPSON,
STEVE SYMMS,
LLOYD BENTSEN,
QUENTIN N. BURDICK,
FRANK R. LAUTENBERG,

From the Committee on Labor and Human Resources—general conferees:

ORRIN HATCH,
ROBERT T. STAFFORD,
DAN QUAYLE,
EDWARD M. KENNEDY,
CLAIBORNE PELL,

From the Committee on Labor and Human Resources—for PBGC and ERISA Subconference only:

(For the purposes of subconference No. 18 only):

ORRIN HATCH,
DON NICKLES,
STROM THURMOND,
EDWARD M. KENNEDY,
HOWARD M. METZENBAUM,

From the Committee on Finance—for PBGC and ERISA Subconference only:

BOB PACKWOOD,
JOHN CHAFEE,
JOHN HEINZ,
GEORGE MITCHELL,
DANIEL PATRICK MOYNIHAN,

From the Committee on Finance—for Private Health Insurance Coverage Subconference only:

JOHN HEINZ,
DAVE DURENBERGER,
MAX BAUCUS,

From the Committee on Labor and Human Resources—for PBGC and ERISA Subconference only:

ORRIN HATCH,
DON NICKLES,
STROM THURMOND,
EDWARD M. KENNEDY,
HOWARD M. METZENBAUM,

From the Committee on Environment and Public Works:
(For Superfund authorization only):

JOHN H. CHAFEE,
LLOYD BENTSEN,

From the Committee on Governmental Affairs:

W.V. ROTH, Jr.,
TED STEVENS,
WILLIAM S. COHEN,
TOM EAGLETON,
CARL LEVIN,
ALBERT GORE, Jr.,

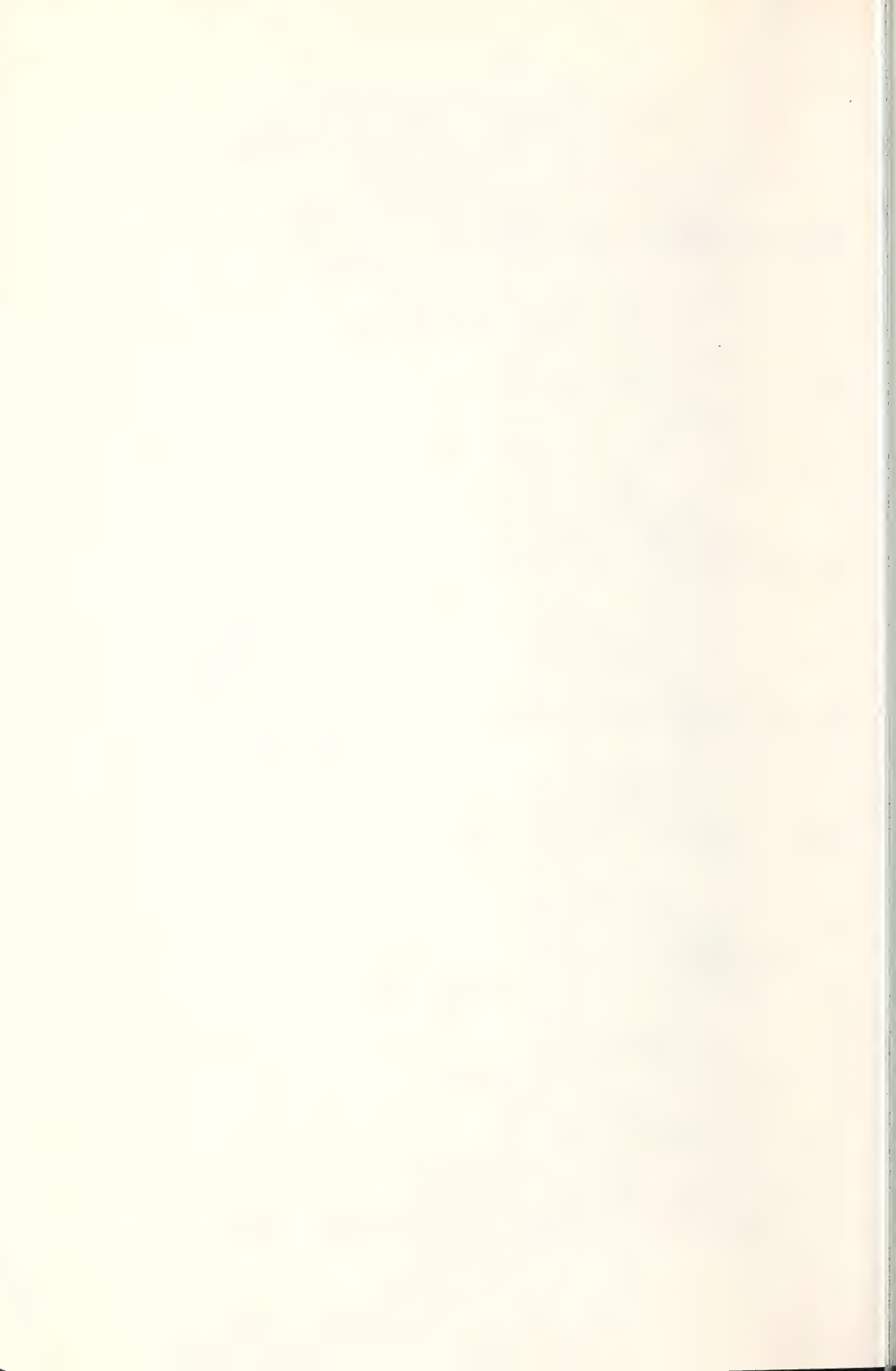
From the Committee on the Budget—general conferees:
PETE V. DOMENICI,

W.L. ARMSTRONG,
NANCY LANDON KASSEBAUM,
RUDY BOSCHWITZ,
FRITZ HOLLINGS,
J. BENNETT JOHNSTON,
HOWARD M. METZENBAUM,

From the Committee on Small Business:

LOWELL P. WEICKER, Jr.,
SLADE GORTON,
DALE BUMPERS,

Managers on the Part of the Senate.



Finder's Aid
P.L. 99-335 (100 Stat. 514) Approved June 6, 1986
Federal Employees' Retirement System Act of 1986

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>S.Rep. 99-166</u>	<u>H.C.Rep.* 99-606</u>
Employment - Service in the Employ of the U.S. Government under Federal Employees' Retirement System and Others (technical amendment)	210(a)(5) (F)	304(a)(1)	606	—	—
Employment - Service in the Employ of the U.S. Government under Federal Employees' Retirement System and Others (technical amendment)	210(a)(5) (G)	304(a)(2)	606	—	—
Employment - Service in the Employ of the U.S. Government under Federal Employees' Retirement System and Others	210(a)(5) (H)	304(a)(3)	606	81	142, 146, 151

* Note: The Senate Conference Report 99-302 is identical to the House Conference Report 99-606.



PUBLIC LAW 99-335—JUNE 6, 1986

**FEDERAL EMPLOYEES' RETIREMENT
SYSTEM ACT OF 1986**

Public Law 99-335
99th Congress

An Act

June 6, 1986
[H.R. 2672]

To amend title 5, United States Code, to establish a new retirement and disability plan for Federal employees, postal employees, and Members of Congress, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Federal
Employees'
Retirement
System Act
of 1986.
New Jersey
International
and
Bulk Mail
Center.

SECTION 1. REDESIGNATION OF BUILDING.

(a) **REDESIGNATION.**—The New York Bulk and Foreign Mail Center in Jersey City, New Jersey, shall hereafter be known and designated as the "New Jersey International and Bulk Mail Center". Any reference to such building in any law, map, regulation, document, record, or other paper of the United States shall be considered to be a reference to the New Jersey International and Bulk Mail Center.

(b) **EFFECTIVE DATE.**—This section shall take effect 6 months after the date of the enactment of this Act.

SEC. 2. DEDICATION OF MICHAEL McDERMOTT PLACE.

(a) **ERECTION OF SIGN.**—The United States Postal Service shall erect a suitable sign bearing the inscription "Michael McDermott Place", anywhere on its property adjacent to the street and parking area located immediately to the east of the New York Bulk and Foreign Mail Center building in Jersey City, New Jersey, so as to dedicate such portion of such street in memory of former postal employee Michael McDermott.

(b) **EFFECTIVE DATE.**—This section shall take effect on the date of the enactment of this Act.

TITLE I—FEDERAL EMPLOYEES' RETIREMENT SYSTEM

SEC. 100. SHORT TITLE; TABLE OF CONTENTS.

5 USC 8401 note.

(a) **SHORT TITLE.**—This Act may be cited as the "Federal Employees' Retirement System Act of 1986".

(b) **TABLE OF CONTENTS.**—The table of contents is as follows:

TABLE OF CONTENTS

TITLE I—FEDERAL EMPLOYEES' RETIREMENT SYSTEM

Sec. 100. Short title; table of contents.

Sec. 100A. Purposes.

Sec. 101. Establishment.

TITLE II—OTHER AMENDMENTS TO TITLE 5 OF THE UNITED STATES CODE

Sec. 201. Treatment under Civil Service Retirement System of certain individuals excluded from Federal Employees' Retirement System.

Sec. 202. Non-applicability of Civil Service Retirement System to individuals under Federal Employees' Retirement System.

- Sec. 203. Pay for the Executive Director of the Federal Retirement Thrift Investment Board.
- Sec. 204. Alternative forms of annuities.
- Sec. 205. Retirement counseling.
- Sec. 206. Participation by certain employees and Members only in the Thrift Savings Plan.
- Sec. 207. Miscellaneous amendments.

TITLE III—OTHER PROVISIONS RELATING TO THE FEDERAL EMPLOYEES' RETIREMENT SYSTEM AND THE CIVIL SERVICE RETIREMENT SYSTEM

- Sec. 301. Elections.
- Sec. 302. Effect of an election under section 301 to become subject to the Federal Employees' Retirement System.
- Sec. 303. Provisions relating to an election to become subject to chapter 83 subject to certain offsets relating to Social Security.
- Sec. 304. Amendments relating to Social Security.
- Sec. 305. Extension of Federal Employees' Retirement Contribution Temporary Adjustment Act of 1983; refund of excess contributions.
- Sec. 306. Applicability to the United States Postal Service.
- Sec. 307. Use of "normal-cost percentage".
- Sec. 308. Retirement study.
- Sec. 309. Repeal of automatic transfer provision.
- Sec. 310. Disclosure of return information.
- Sec. 311. Initial appointments to the Federal Retirement Thrift Investment Board.
- Sec. 312. Plan for delayed contributions to the Thrift Savings Fund.

TITLE IV—FOREIGN SERVICE RETIREMENT

- Sec. 401. Short title; references to Foreign Service Act of 1980.
- Sec. 402. Redesignation of certain provisions of the Foreign Service Act of 1980.
- Sec. 403. Definition of court.
- Sec. 404. Creditable service for purposes of subchapters I and II.
- Sec. 405. Contributions to the Foreign Service Retirement and Disability System.
- Sec. 406. Offset of annuity by the amount of Social Security benefits.
- Sec. 407. 18-month period to elect survivor annuity.
- Sec. 408. Alternate forms of annuities.
- Sec. 409. Treatment of certain recall service.
- Sec. 410. Reemployment.
- Sec. 411. Comparability between the Federal Employees' Retirement System and the Foreign Service Pension System.
- Sec. 412. Moderation of remarriage penalty.
- Sec. 413. Lump-sum payments.
- Sec. 414. Exclusion of participants in Foreign Service Pension System from Foreign Service Retirement and Disability System.
- Sec. 415. Foreign Service Pension System.
- Sec. 416. Table of contents.
- Sec. 417. Effective date.

TITLE V—CENTRAL INTELLIGENCE AGENCY RETIREMENT AND RELATED MATTERS

- Sec. 501. References.
- Sec. 502. Contributions to the Central Intelligence Agency Retirement and Disability System.
- Sec. 503. Offset of annuity by the amount of Social Security benefits.
- Sec. 504. Thrift savings fund participation by participants in the Central Intelligence Agency Retirement and Disability System.
- Sec. 505. Alternative forms of annuities.
- Sec. 506. Participation in the Federal Employees' Retirement System.
- Sec. 507. Special retirement accrual for other intelligence personnel.

TITLE VI—MISCELLANEOUS PROVISIONS

- Sec. 601. Annuities for survivors of District of Columbia judges.

TITLE VII—AUTHORIZATION OF APPROPRIATIONS; EFFECTIVE DATES

- Sec. 701. Authorization of appropriations for certain expenses of the Federal Retirement Thrift Investment Management System.
- Sec. 702. Effective dates.

SEC. 100A. PURPOSES.

The purposes of this Act are—

42 USC 401.

- (1) to establish a Federal employees' retirement plan which is coordinated with title II of the Social Security Act;
- (2) to ensure a fully funded and financially sound retirement benefits plan for Federal employees;
- (3) to enhance portability of retirement assets earned as an employee of the Federal Government;
- (4) to provide options for Federal employees with respect to retirement planning;
- (5) to assist in building a quality career work force in the Federal Government;
- (6) to encourage Federal employees to increase personal savings for retirement; and
- (7) to extend financial protection from disability to additional Federal employees and to increase such protection for eligible Federal employees.

SEC. 101. ESTABLISHMENT.

(a) IN GENERAL.—Title 5, United States Code, is amended by inserting after chapter 83 the following new chapter:

“CHAPTER 84—FEDERAL EMPLOYEES’ RETIREMENT SYSTEM

“SUBCHAPTER I—GENERAL PROVISIONS

“Sec.

“8401. Definitions.

“8402. Federal Employees’ Retirement System; exclusions.

“8403. Relationship to the Social Security Act.

“SUBCHAPTER II—BASIC ANNUITY

“8410. Eligibility for annuity.

“8411. Creditable service.

“8412. Immediate retirement.

“8413. Deferred retirement.

“8414. Early retirement.

“8415. Computation of basic annuity.

“8416. Survivor reduction for a current spouse.

“8417. Survivor reduction for a former spouse.

“8418. Survivor elections; deposit; offsets.

“8419. Survivor reductions; computation.

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"SUBCHAPTER I—GENERAL PROVISIONS**"§ 8401. Definitions**

5 USC 8401.

"For the purpose of this chapter—

"(1) the term 'account' means an account established and maintained under section 8439(a) of this title;

"(2) the term 'annuitant' means a former employee or Member who, on the basis of that individual's service, meets all requirements for title to an annuity under subchapter II or V of this chapter and files claim therefor;

"(3) the term 'average pay' means the largest annual rate resulting from averaging an employee's or Member's rates of basic pay in effect over any 3 consecutive years of service or, in the case of an annuity under this chapter based on service of less than 3 years, over the total service, with each rate weighted by the period it was in effect;

"(4) except as provided in subchapter III of this chapter, the term 'basic pay' has the meaning given such term by section 8331(3);

"(5) the term 'Board' means the Federal Retirement Thrift Investment Board established by section 8472(a) of this title;

under section 8334(k) of such title if such individual's pay had been subject to such section during such period;

(B) for any period of service beginning on January 1, 1984, and ending on December 31, 1986, there is deposited to the credit of the Fund an amount equal to 1.3 percent of basic pay for such period; and

(C) for any period of service before January 1, 1984, there is deposited to the credit of the Fund any amount required with respect to such period under such subchapter.

(2) A deposit under this subsection may be made by the individual or, for purposes of survivor annuities, a survivor of such individual.

SEC. 304. AMENDMENTS RELATING TO SOCIAL SECURITY.

(a) AMENDMENTS TO SOCIAL SECURITY ACT.—Section 210(a)(5) of the Social Security Act is amended—

42 USC 410.

(1) by striking out “or” at the end of subparagraph (F);

(2) by striking out the semicolon at the end of subparagraph (G) and inserting in lieu thereof “, or”; and

(3) by adding at the end thereof the following:

“(H) service performed by an individual on or after the effective date of an election by such individual under section 301(a) of the Federal Employees’ Retirement System Act of 1986, or under regulations issued under section 860 of the Foreign Service Act of 1980 or section 307 of the Central Intelligence Agency Retirement Act of 1964 for Certain Employees, to become subject to chapter 84 of title 5, United States Code;”.

Post, p. 619.

Post, p. 628.

Ante, p. 517.

(b) AMENDMENTS TO THE INTERNAL REVENUE CODE OF 1954.—Section 3121(b)(5) of the Internal Revenue Code of 1954 is amended—

26 USC 3121.

(1) by striking out “or” at the end of subparagraph (F);

(2) by striking out the semicolon at the end of subparagraph (G) and inserting in lieu thereof “, or”; and

(3) by adding at the end thereof the following:

“(H) service performed by an individual on or after the effective date of an election by such individual under section 301(a) of the Federal Employees’ Retirement System Act of 1986, or under regulations issued under section 860 of the Foreign Service Act of 1980 or section 307 of the Central Intelligence Agency Retirement Act of 1964 for Certain Employees, to become subject to chapter 84 of title 5, United States Code;”.

SEC. 305. EXTENSION OF FEDERAL EMPLOYEES’ RETIREMENT CONTRIBUTION TEMPORARY ADJUSTMENT ACT OF 1983; REFUND OF EXCESS CONTRIBUTIONS.

(a) EXTENSION.—The Federal Employees’ Retirement Contribution Temporary Adjustment Act of 1983 (97 Stat. 1106; 5 U.S.C. 8331 note) is amended—

(1) in sections 202(6), 203(a)(4)(A), 203(a)(4)(B), 204(a), and 206(b)(2)(A)(i) by striking “May 1, 1986” each place it appears and inserting “January 1, 1987”, and in sections 202(1) and 206(c)(3) by striking “January 1, 1986” and inserting “January 1, 1987”; and

(2) in subsections (b) and (c) of section 205, by striking out “and 1986” and inserting in lieu thereof “1986, and 1987”.

(b) REFUNDS.—(1) The amendments made by subsection (a) shall be effective as of May 1, 1986.

Effective date.

5 USC 8331 note.

(2) As used in paragraph (1), the term “base quarter” has the meaning provided by section 8462(a)(1) of title 5, United States Code (as added by section 101 of this Act).

Approved June 6, 1986.

LEGISLATIVE HISTORY—H.R. 2672 (S. 1527):

HOUSE REPORT No. 99-606 (Comm. of Conference).

SENATE REPORTS: No. 99-166 accompanying S. 1527 (Comm. on Governmental Affairs) and No. 99-302 (Comm. of Conference).

CONGRESSIONAL RECORD:

Vol. 131 (1985): July 8, considered and passed House.

Nov. 7, considered and passed Senate, amended, in lieu of S. 1527.

Vol. 132 (1986): May 20, Senate agreed to conference report.

May 22, House agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS: Vol. 22, No. 23 (1986): June 6, Presidential statement.



99TH Congress
1st Session

SENATE

REPORT
99-166

FEDERAL RETIREMENT REFORM ACT OF
1985

R E P O R T

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

TO ACCOMPANY

S. 1527

To amend title 5, United States Code, to establish a new retirement and disability plan for Federal employees, postal employees, and Members of Congress, and for other purposes



OCTOBER 30 (legislative day, OCTOBER 28), 1985.—Ordered to be printed

COMMITTEE ON GOVERNMENTAL AFFAIRS

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FEDERAL RETIREMENT REFORM ACT OF 1985

OCTOBER 30 (legislative day, OCTOBER 28), 1985.—Ordered to be printed

Mr. ROTH, from the Committee on Governmental Affairs,
submitted the following

REPORT

[To accompany S. 1527]

The Committee on Governmental Affairs, to which was referred the bill (S. 1527) to amend title 5, United States Code, to establish a new retirement and disability plan for Federal employees, postal employees, and Members of Congress, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and recommends that the bill as amended do pass.

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I. BACKGROUND AND HISTORY

The Civil Service Retirement System (CSRS) was established in 1920 as a way to retire superannuated employees from the civil service. It was one of the very early retirement programs in this country. The Social Security system was established in 1935 to provide a foundation of economic security for the elderly retiring from commerce and industry. At the time of enactment of the Social Security program, consideration was given and rejected to include Federal workers under the program. Until 1983, coverage of Feder-

al employees under Social Security was often proposed and rejected for a variety of reasons.

In the fall of 1981, President Reagan established the National Commission on Social Security Reform to review the financial health of the Social Security system and to recommend ways to shore up its short and long term financial shortfalls. In January 1983, the Commission recommended, among other things, covering newly hired Federal employees under the Social Security program. Enactment of that proposal followed with the passage of the Social Security Amendments of 1983.

The legislation actually provided that Federal employees newly hired on or after January 1, 1984, or rehired on or after that date with separation from Government service for more than 365 days, would be covered by Social Security for such new service. The legislation also covered all current Members of Congress and political appointees in the executive branch at the equivalent of a GS-16 level or higher.

Social Security coverage of Federal employees forced a congressional decision with regard to additional retirement coverage for such employees. The primary question was: Should such employees also be covered by the CSRS with its redundant coverage and contribution amounts or should these employees have a new Federal retirement program designed to coordinate with Social Security?

In the summer of 1983 at a hearing before the Senate Subcommittee on Civil Service, Post Office, and General Services, the General Accounting Office released a report and testified that dual coverage under both Social Security and CSRS would clearly create recruitment problems for the Federal Government without some relief from the dual contributions required by both programs. Later that year a Senate amendment was added to an unrelated House bill establishing a 2-year interim arrangement (Federal Employees Temporary Adjustment Act of 1983, Public Law 98-168) which effectively reduced the employee contribution amounts to CSRS. This arrangement was to expire after December 31, 1985, unless a new plan was established, thereby requiring all employees covered by Social Security to begin paying the full CSRS contribution. In addition, for such employees to receive CSRS contribution would have to be repaid.

This interim plan was proffered and adopted to afford Congress sufficient time to design a supplemental Federal retirement program coordinated with Social Security. Thus, Congress effectively decided at that time to begin the design of a new Federal retirement program to be coordinated with Social Security.

Social Security and typical employer retirement plans have very different benefit provisions and very different objectives. Social Security is, in part, a social insurance program redistributing wealth from high to low income workers. In contrast, an employer retirement program is a staff retirement plan which normally attempts to replace a certain percentage of an employee's preretirement earnings at all income levels. Social Security provides a floor of income for the retired, the disabled and for survivors of workers. Retirement programs, in a sense, defer wages. Coordinating the two into a new Federal retirement program, while readily feasible,

calls for the most significant changes in Federal retirement practices since the establishment of CSRS.

In December 1981 the Congressional Research Service issued a report, "Restructuring the Civil Service Retirement System: Analysis of Options to Control Costs and Maintain Retirement Income Security," outlining four options to coordinate a new Federal retirement plan with Social Security. Based on that report, legislation was introduced by Senator Stevens in the fall of 1982, S. 2905, establishing a 3-tier pension plan with Social Security serving as a base. The Senate took no further action until the establishment of the interim plan in late 1983.

During 1984 the Senate Subcommittee on Civil Service sponsored five Federal pension forums, which brought experts from the non-Federal sector to discuss the various types of plans utilized by private industry and State and local governments. The published discussions of these forums covered topics such as Social Security integration, pension funding, investments, and various retirement plan components. In the meantime, at the request of the Senate subcommittee, the General Accounting Office issued two companion reports in 1984. The first, "Features of Nonfederal Retirement Programs," June 26, 1984, detailed typical retirement practices found in the non-Federal sector such as normal retirement age, cost of living adjustments, etc., while the second, "Benefit Levels of Nonfederal Retirement Programs," February 26, 1985, described the range of benefits expected to be payable from non-Federal programs at retirement using a constant set of economic and demographic assumptions.

On July 30, 1985, S. 1527 was introduced by Senators Stevens and Roth. The committee held 2½ days of hearings on the legislation on September 10-12, 1985. On October 2, 1985, the committee marked up the bill. At that time a bipartisan substitute for S. 1527 was offered by Senators Roth, Stevens, Eagleton, and Gore. It was adopted unanimously by the committee.

Few issues before the Governmental Affairs Committee have been subject to such extensive study and discussions as the new retirement plan. The committee has utilized numerous Government and private sources to develop the plan. Large bodies of information exist substantiating the committee's work, such as Congressional Research Service reports, General Accounting Office reports and the prints of the five forums.

STATEMENT

An employer's retirement plan is not designed in a vacuum. Many factors influence the eventual structure and provisions of a plan. Most importantly, an employer must first decide the type of workforce desired and then design a retirement plan that helps influence the desired workforce characteristics. The goal of a retirement plan is to maintain one's preretirement standard of living.

In the 1920's the Federal Government was considerably smaller and far less involved in the daily lives of individual citizens than now. The composite of the Federal workforce, today, mirrors that of the Nation's. Electricians, engineers, teachers, mechanics, law-

yers, doctors, and secretaries are just a few of the hundreds of occupations existing in the Government.

During the past 65 years the dynamism of this Nation has forced the Federal Government to take a more active role in society than envisioned in 1920. From rejection of the League of Nations to the world's most philanthropic and influential Nation, from a racially segregated society to a largely integrated one, from a stationary society to a mobile one, from a largely uneducated society to a highly educated one, from a primarily agrarian economy to a highly industrialized and technological one, the Federal Government has assumed an active role in all of these developments. Such a role requires a highly competent and dynamic workforce. As our society becomes increasingly more complex, the Federal Government must have the ability to attract and retain highly qualified individuals in all occupations who can meet the changing needs of our Government and society.

An attractive, flexible retirement plan can assist the government in meeting these objectives. The Committee concludes that a Federal retirement plan should continue to offer incentives to build a career workforce. Any employer must have a cadre of employees to provide stability, continuity and the institutional memory to run an organization effectively, particularly one as large and diverse as the Federal Government.

The committee also finds that increased mobility of Federal employees in and out of Government, particularly during midcareer, is desirable. The Government's workforce needs institutional expertise devolving from career workers as well as fresh ideas and methods that originate from employees having extensive experience in private industry. Currently, Federal recruitment from private sector management levels is rare, so that Federal managers are almost totally promoted from within. The committee believes that such promotion arrangements are to be encouraged, but not to the exclusion of hiring those from the outside. The committee feels that a Federal retirement plan should be attractive to assist in recruiting midcareer employees.

The committee also finds that the Government would be best served by retaining the employees who want to work for the Government, while permitting those who want to leave the ability to do so. Currently, the CSRS locks employees into a system that is generous but inflexible. Many of these employees would prefer to work elsewhere but cannot afford to relinquish their rights to good retirement benefits. This results in the Government's retaining some demoralized and inefficient employees. Greater portability of benefits abates the significance of this problem.

The committee finds that employee financial needs vary during their work career, as well as during retirement. Because employees usually are the best judges of their own needs, private industry often designs employee compensation programs around the concept of employee choice. In addition, a certain degree of flexibility with respect to the amount of disposable income an employee can set aside for retirement gives employees greater involvement in their careers and in decisions affecting their ultimate retirement benefits. The committee also believes employees ought to share directly

in retirement by encouraging greater savings by employees for retirement.

Finally, for an enterprise to survive it must keep its costs under control. Compensation is a major cost for any organization, such as the Government, and retirement can account for 15-25 percent of payroll. Related to cost is how a retirement plan is funded. Retirement costs, unlike other costs, do not necessarily surface until many years after the establishment of a plan. Federal law, however, requires private employers to prefund their plans to a certain extent to ensure the availability of assets to pay for benefits when they come due. The committee finds that the cost of the Federal Government plan should be on a par with corporate plans. Additionally, the committee believes that the Government should pre-fund its plan to avoid the revelation of startling costs at a later period.

S. 1527 as amended meets all of the objectives that the committee finds necessary in designing a new Federal retirement package. Using a computer model developed by the Congressional Research Service to provide a cost and benefit analysis of a new Federal retirement plan, the committee concludes that the benefits that will accrue under S. 1527 will encourage career employment with the Federal Government. In fact, in many cases, career Federal employees will receive greater benefits than under CSRS if they participate in the thrift plan.

In addition, the portable nature of Social Security coverage coupled with a highly portable thrift plan component of this retirement package should make Federal employment attractive to private sector employees in midcareer. Such portability also will clearly loosen the restraints on the exodus of dissatisfied Federal employees.

S. 1527 provides a unique benefit to employees in that they will be given a choice between two different retirement plans. Both are three-tiered plans. The design of one is more weighted to the thrift plan, while the other is more weighted to the defined benefit plan. This gives new entrants maximum choice with regard to their futures.

The thrift plan component of S. 1527 provides employees significant flexibility with respect to their level of contributions and how they want those contributions invested. It also encourages Federal employees to save toward their own retirement.

Finally, the cost and benefits of S. 1527 are comparable to those offered by most large private sector companies, thus enabling the Government to compete with private industry for talent by providing attractive benefits while holding down the costs to a reasonable level.

MAJOR PROVISIONS IN S. 1527

Establishment of chapter 84

The Federal Retirement Reform Act of 1985 represents a dramatic new development in Federal retirement programs. The Federal Retirement System (FRS) established by S. 1527 sets up a complete retirement program to coordinate with Social Security. It captures some of the best features of pension plans frequently used by pri-

vate industry to supplement Social Security. The three tiers of FRS—Social Security, defined benefit, and the defined contribution or thrift plan—are combined to offer a sound retirement program which provides considerable career flexibility and involvement in financial decisionmaking for Federal employees. FRS is a fully funded and financially sound retirement program at a reasonable cost to the Government. FRS could likely become a prototype retirement plan for others.

Although there are common elements between the FRS and the existing Civil Service Retirement System (CSRS), the two will generally function as separate retirement programs. That is, employees now covered by the CSRS retain the CSRS benefits without change unless they personally elect to enter the new system. The Civil Service Retirement and Disability Fund of the CSRS, a defined benefit plan, will also be the fund used for the defined benefit portion of the 3-tiered FRS. Other than this linkage, the two systems are quite different in regard to the employees covered, retirement eligibility requirements, benefits, and basic design. Rather than amending Chapter 83 of Title 5, United States Code (U.S.C.), an administratively burdensome task, S. 1527 establishes a new Chapter 84 in 5 U.S.C. The committee intends for FRS to be the retirement plan design of the future. In addition to the administrative concerns, the committee believes establishing Chapter 84 clearly sets FRS up as a separate system.

Many of the definitions in FRS are the same or similar to those now used in the current system, although several new or revised ones have been added. One significant change is the definition of "average pay". Average pay under FRS means the highest average rate of basic pay in effect over any 5 consecutive years of creditable service as opposed to the "high 3" years of the CSRS. This "high 5" definition more closely conforms to prevailing private industry practice and was one of many features of private sector retirement programs adopted in S. 1527. This serves to reduce the overall cost of the pension plan.

The definition of "basic pay" is broadened to include the pay rate established by law regardless of appropriation limits on the authority to pay. In cases where the Congress through the appropriation process sets a pay cap or limits employee pay to a level less than the statutory pay rate, the average pay for an employee would be computed using the statutory pay rate rather than the actual salary. Therefore, an individual's annuity and amount available for the thrift plan would reflect the pay level to which an employee was actually entitled. The committee believes an individual should not be doubly penalized by capping wages during the working years and using the capped wages for computing the annuity in retirement.

The definitions of "firefighter" and "law enforcement officer" are made more specific to include only positions with duties requiring young and physically able employees who serve at least 10 years in those positions or move from those positions after 10 years of service into managerial positions. Application of these definitions will exclude other positions associated with firefighting and/or law enforcement which are not necessarily physically demanding. Employees meeting these definitions are entitled to earlier re-

tirement than others, i.e., age 50 and 20 years of service, or 25 years of service at any age, and to annuity supplements beginning at retirement until age 62 which are equivalent to the value of Social Security benefits payable at age 62. These provisions of the retirement program are costly. The committee intended to restrict application to employees in these special classes who are faced with earlier retirement because of the physical requirements of their jobs.

Coverage

The committee reviewed the issue of who, in addition to Federal workers covered by the Social Security Amendments of 1983, should be covered by the FRS. For instance, a number of Federal employee groups, such as those employed by the Tennessee Valley Authority, nonappropriated fund instrumentalities, and farm credit districts, have for many years been covered by Social Security and their own Federal retirement system. In addition, the Foreign Service, the Central Intelligence Agency, and the Federal Reserve have retirement systems separate from CSRS.

Other groups such as the District of Columbia, the U.S. Park Police, the U.S. Secret Service, Gallaudet College, and county committees are, or have at one time been, included as Federal employees for purposes of the CSRS. Members of Congress and Congressional employees were covered by the CSRS only if they elected such coverage.

The committee finds that, to the extent possible, Federal employees should be covered by the same retirement system. Major disruptions to longstanding retirement arrangements are not considered appropriate at this time, however. Therefore, other Federal retirement systems which have Social Security as a base are not affected by this legislation. The FRS will apply to employees of Gallaudet College and the county committees. District of Columbia employees, who are not covered by Social Security, will not be included in the FRS. Further, since the CSRS is now essentially a closed retirement system, new District of Columbia employees will be excluded from it.

The committee also finds that Members of Congress and congressional staffs should be covered by the FRS in the same way as all other Federal employees. Further, the committee believes that the U.S. Park Police and the U.S. Secret Service, now included in the District of Columbia retirement system for municipal police and firemen, should be covered by the FRS. Permitting certain groups of Federal employees to participate in the District retirement system creates inequities between these employees and other Federal personnel.

The Foreign Service, the Central Intelligence Agency, and the Federal Reserve retirement systems are not affected by this bill. However, the committee expects to work with their respective oversight committees to assure that system modifications necessary to recognize Social Security coverage of new employees in one of these retirement systems are consistent with the FRS.

The committee has determined that individuals covered by the FRS who are also credited with service under the CSRS should be treated the same way when at all possible. Three situations when

this could occur are: Rehire after a break in service of more than one year, transfer from the CSRS, and reemployment of an annuitant under a Government retirement system other than the FRS.

In general, the CSRS rules will continue to apply to service under the CSRS. For example, a rehire or transfer who had 10 years of service under the CSRS and then worked 20 years under FRS may elect to retire at age 55. Since both periods are treated as a single total for eligibility purposes, a full 30 years of service would be recognized. The reduction for early retirement under the FRS, then, would be 2 percent rather than 5 percent. In determining the amount of benefit payable, however, the 10 years under CSRS would be computed under the CSRS benefit formula and added to the amount computed under the FRS formula for the 20 years under that system. The same general principle applies to shorter periods of service, too. For example, a combination of 3 years under the CSRS and 7 years under the FRS would qualify the employee to apply for an annuity under the FRS at 55. The 3 years of service under the CSRS, even though insufficient by itself to earn a CSRS benefit, would nevertheless use the CSRS benefit computation rules. However, payment for the CSRS portion of the benefit would be delayed until age 62, since service of 10 years would not result in payment from CSRS until that age.

A reemployed annuitant from a Government retirement system other than the FRS will have his or her annuity treated in whatever manner is prescribed by the rules of that retirement system during the period of reemployment. For example, a discontinued service annuity will terminate and restart after employment ceases, while an optional retirement annuity will continue and pay will be reduced to reflect the amount of the annuity received. A person whose annuity continues is not subject to Social Security, so any post-retirement service is treated under the rules of chapter 83. A person whose annuity stops, however, is subject to Social Security and the FRS. In both cases, average pay may be increased to reflect higher earnings during service under the FRS.

A rehire who withdrew his or her contributions from the CSRS must redeposit the money in order to receive credit for the service under the CSRS benefit formula.

Two options

S. 1527, as amended, incorporates a unique feature in retirement planning. Because of the size and diversity of the Federal workforce, the committee finds that offering more than one retirement plan to employees will make the plan attractive to a wider range of employees. One of the attractions of the Federal Employee Health Benefits Program is the variety of choices in health coverage. Similarly, the committee believes providing a limited choice of two retirement plans, equivalent in cost, but different, will be very attractive to potential employees of the Government.

Employees will choose within 60 days after they begin employment the retirement plan in which they wish to participate. The election is irrevocable for life.

In option A the basic annuity is fully paid for by the Government and provides an annual accrual rate of 0.9 percent per year of service for the first 15 years of service and 1.1 percent for the

remaining years, multiplied by the employee's high-5 average salary. Unreduced benefits are available at age 62. Benefits are also available at age 55 with 30 years of service with a 2-percent reduction for each year under 62. An employee's defined benefit is adjusted for inflation after retirement beginning at age 62, with the annual adjustment equal to the rate of increase in the Consumer Price Index (CPI) minus two points from age 62 to age 67 and 100 percent on the CPI rate at age 67 and above.

Finally, option A includes a thrift plan in which the Government will match dollar for dollar the first 5 percent of an employee's salary.

Option B requires employees to contribute to the defined benefit plan the difference between the normal CSRS contribution and the OASDI tax. This means that employees contribute 7 percent on any salary in excess of the Social Security wage base, while contributing only a nominal amount on salary to the defined benefit plan up to the wage base (1.3 percent in 1987, 0.94 percent in 1988-89 and 0.8 percent after 1989). The march on the thrift plan is different from option 1 in that the first 1 percent of salary is matched dollar for dollar, percentage points 2 and 3 are matched at 50¢ on a dollar, and percentage points 4, 5, and 6 are matched at 25¢ on a dollar.

In turn an employee can retire at age 55 with 30 years of service with unreduced benefits from the defined benefit plan. Survivor and disability benefits are somewhat improved over option A. Finally, post-retirement inflation protection on the defined benefit plan is CPI minus two points for retirement under agree 62 and full CPI at age 62 and above.

In essence, option A contains more flexibility and portability through a richer thrift plan. Option B contains more security with a richer and infation-protected defined benefit plan.

Retirement eligibility under basic plan

S. 1527 makes some significant changes from CSRS in the age and service requirements for retirement eligibility. These changes will provide a degree of career flexibility to Federal workers not currently available in the CSRS. Under CSRS, an employee may retire as early as 55 years of age with 30 years of service and receive an unreduced annuity. Full retirement at 55 is a costly provision of the CSRS and a practice rarely found in comparable private sector pension plans. What is more commonly found in private industry is a retirement age of 62 for full benefits, with options to retire at 55 with a reduced annuity to compensate for the longer payment period.

The committee chose to follow the private industry pattern by raising the age requirement for retirement with full benefits and adding alternatives for early retirement with appropriate annuity reductions, unless the employee chose the second option, in which case the employee's mandatory contribution pays for the early retirement benefit. S. 1527 provides for full retirement at age 62 with 5 years of service. In addition to being the most common age for retirement in the private sector, 62 is also the age at which reduced Social Security benefits are payable. Whend the majority of the persons covered by the FRS retire, the age at which unreduced

Social Security benefits are payable will have risen to 67. S. 1527 allows for retirement at age 55 with 30 years of service, as in CSRS, but with a benefit reduction of 2 percent for each year under 62 unless Option B was chosen. The legislation also permits early retirement at age 55 with 10 years' service with a reduction of 5 percent for each year under 62.

Special classes—law enforcement officers, firefighters, and air traffic controllers—may retire with unreduced annuities at age 50 with 20 years of service or at any age with 25 years of service. National guard technicians may do so at age 55 with 30 years.

S. 1527 has tightened the definitions of law enforcement officers and firefighters over the provisions of CSRS. The committee recognizes the need for an earlier retirement age because of physically demanding occupations and has set that age at 50 for unreduced benefits. But the committee believes this benefit should be reserved to those positions which require youthful employees.

The pension plan presented in S. 1527 offers the greatest benefit to the full career worker. However, unlike the current CSRS which more or less "locks in" Federal employees and penalizes those who leave prior to retirement, S. 1527 offers attractive opportunities to other workers for short, middle-length, interrupted or second careers, whatever may fit their individual situations. Employees become vested in the basic pension plan after 5 years and retain the right to a deferred pension payable at age 62 or a deferred reduced pension at 55 with 10 years service.

Benefits under basic plan

Computation of annuity

The basic annuity amount is computed by multiplying the accrual rate in each option by years of service by the average pay (high 5). Accrual rates have a direct bearing on benefit amounts—the higher the accrual rate the higher the benefit. They vary considerably among various pension plans depending on whether or not the plan is an "add-on" or "integrated" with Social Security benefits. They may also vary to achieve desired workforce characteristics—higher accrual rates during early years of employment favor short career employment, while higher rates during later years of employment encourage longer careers for employees. The current CSRS falls into this second category.

The committee believes the CSRS practice of backloading the benefit, in other words, giving greater weight to later years of employment, should be continued to reward full career employment. Thus, in each option a varied accrual rate is provided.

The basic pension plan in S. 1527 is "added-on" rather than "integrated" with Social Security. This preserves the "tilt" in Social Security benefits by which lower paid employees get proportionately more of their preretirement earnings than higher income employees. The committee designed the plan to protect lower income employees from, in essence, having to participate in the thrift plan to ensure a reasonable retirement benefit. Obviously, they may participate if they wish. It is expected that employees at the higher income levels will participate in the thrift plan to a greater degree than lower-paid employees. Therefore, the benefits higher paid em-

ployees get from the thrift plan, when coupled with Social Security and the basic pension plan benefits, will alter the tilt. This is a departure from typical private practice which deliberately tilts the pension away from the employees with lower incomes to flatten the tilt in Social Security benefits.

S. 1527 continues the policy under Chapter 83 of crediting days of unused sick leave in computing an annuity. However, it changes the current CSRS policy for computing the annuity of employees who have worked part-time. Under the CSRS the annuity is computed by multiplying the accrual rate by the "high 3" average pay by years of service. Since the years of service count the same whether through full-time employment or part-time employment, the high-3 earnings are the key in determining the annuity amount. This policy makes it financially impractical for employees to work part-time toward the end of their careers. It essentially prohibits employees from phasing into retirement, an option which may be attractive to the employee and the Government. On the other hand, under CSRS an employee could work full-time only for the final 3 years of employment and achieve the same annuity as an employee with an identical "high 3" who has worked full-time for an entire career. This could be costly depending on the frequency.

S. 1527 changes this policy by crediting part-time employment on a proportional basis but using the annual rate of basic pay payable for full-time service. The committee believes this provision is more fair to the employee and the employer and may reduce costs over the long run.

Reductions for survivor annuities

S. 1527 provides for a 10 percent reduction in an annuity if the employee elects at retirement to provide for a survivor annuity. Under the current CSRS, an employee who selects a joint and survivor option is subject to a reduced pension. However, the pension is reduced by less than 10 percent and is, therefore, subsidized to a greater extent by the Government. A 10-percent reduction still subsidizes the survivor benefit but to a lesser extent than CSRS.

Under S. 1527, the reduction in the annuity to provide for survivor benefits would change to reflect any change in circumstances for entitlement to an annuity because of a change in marital status, an election relating to a former spouse or except under Option A, the death of a spouse. In the case of an annuitant whose pension has been reduced to provide for joint and survivor benefits, the pension returns to the unreduced amount if the spouse dies first only in option B. Option A maintains the reduced benefit for the remainder of the annuitant's life.

Cost-of-living adjustments

S. 1527 provides for different annual cost-of-living adjustments (COLAs) to be made in the basic pension plan depending upon the option chosen. In option A no COLA is provided for retirees between ages 55 and 62; a COLA of CPI minus two is provided for retirees aged 63 through 66 and a full COLA is provided for those beginning at age 67. Clearly, it is less than the full CPI protection provided in the current system. This significant change was made

for several reasons. Full COLAs are one of the two costliest features of the current CSRS. In private industry, the common practice is to make cost-of-living adjustments on an ad hoc rather than annual basis. In addition, the adjustments are typically less than the full increase in CPI, usually up to one-half.

In designing this option, the committee chose the automatic approach as more certain for retirees but reduced the full CPI adjustment for younger retirees. Social Security benefits are fully indexed by the CPI. The committee believes that the reduced COLAs provided for younger retirees are justified in that these retirees can still supplement their income. As one gets older the need for full inflation protection on a fixed income increases.

For individuals selecting option B, full COLAs are provided for all benefits except for the retirement benefits of individuals between the ages of 55 and 62. These "early retirees" receive COLAs equal to CPI minus 2. This policy contrasts with the current system in which full COLAs are provided for retirees regardless of whether or not they retire before 62.

Benefit supplement for special classes

Law enforcement officers, firefighters, and air traffic controllers may retire with unreduced annuities at age 50 with 20 years of service or at any age after 25 years of service. Although eligible to receive unreduced benefits from the defined benefit plan at 50 or before, these classes are not eligible for Social Security benefits until age 62. Therefore, S. 1527 provides for an annuity supplement which is approximately equal to the Social Security benefit payable at age 62. This allows individuals in these special classes who retire with unreduced annuities at 50, or even earlier to receive total benefits from retirement to age 62 which are equivalent to the benefits payable to annuitants retiring at age 62 from both Social Security and the basic pension.

Methods of payment

S. 1527 provides for several methods of receiving pensions. In addition to the standard method of providing for a monthly annuity to the annuitant for life, S. 1527 offers an option of a joint-and-survivor form. Under the joint-and-survivor method, a joint pension is received in a reduced amount during the years both the annuitant and spouse or other designated person are living. Upon the death of the annuitant, the annuity to the survivor would be reduced to 50 percent and continued to the survivor for life. In the case of an individual who is married on the date of application for the annuity, a joint-and-survivor method must be selected unless jointly waived.

S. 1527 also offers a Social Security level benefit option for those who retire before age 62 when Social Security benefits are payable. This increases the basic annuity payment between the ages of 55 and 62 and reduces the payments beginning at 62 so that the total amount each month is approximately equal before and after Social Security begins at 62. The total value of the benefits payable remains the same with no additional costs to the employer.

The committee intends for OPM to offer other options for annuity payments which allow individuals to make selections best suited

to their individual circumstances. Just as S. 1527 provides retirement eligibility alternatives and career planning flexibility, the committee believes that similar choices for method of payment should be available. The committee believes OPM should consider methods frequently used in private industry. One example is life annuity certain whereby an annuitant is guaranteed a specified number of monthly payments whether the annuitant lives or dies before that time but guaranteed for the life of the annuitant who lives beyond the guaranteed time. Another option might be a joint and survivor option which provides less than 50 percent reduction to the survivor.

THRIFT PLAN

The General Accounting Office report to the committee entitled, "Features of Nonfederal Retirement Programs," June 26, 1984, reported that various pension surveys of the private sector found that most companies utilized some type of capital accumulation plan (CAP) to supplement the employer pension plan. For example, the largest survey, conducted by the Bureau of Labor Statistics, found that $\frac{3}{4}$ of the companies they surveyed utilized such a plan. CAPs cover a variety of plans including stock options, profit sharing and thrift plans.

CAPs are advantageous to both the employer and the employee. The costs are defined from year to year and thus avoid open ended pension liabilities for the employer. Employees enjoy them because of their portable nature, their inherent flexibility and their potential for investment growth.

A thrift plan, unlike other CAPs, is offered to employees on a voluntary basis, since it requires employee contributions. These contributions are typically matched to a certain extent by the employer. The contributions flow to individual employee accounts and are invested either by the employer or a board of trustees. Employees normally have access to the accounts upon separation from the employer or retirement. Employer contributions and earnings on the accounts are tax deferred until withdrawal. The Internal Revenue Service has interpreted the Internal Revenue Code to also allow tax deferral of employee contributions to a thrift plan under certain restrictions.

Thrift plans are very popular with employees at all income levels. Even at low income levels, 60-70 percent participation rates are common. Obviously, at higher income levels participation rates approach 100 percent.

Thrift plans are also provided in certain specialized retirement plans which cover such Federal entities as the Federal Reserve Board, the Tennessee Valley Authority, the Federal Deposit Insurance Corporation, and the Comptroller of the Currency. The committee finds no good reason to deny the majority of the Federal workforce this benefit. For the Federal Government to be competitive in its hiring practices, it must accord its employees at least some of the creative compensation items offered in private industry.

handled or an amount no less than \$1,000. The maximum amount shall be \$500,000 except when set at a greater amount by the Secretary of Labor after due notice. It also provides that the amount of funds handled during the preceding fiscal year or the estimated amount during the current fiscal year will determine the amount of the bond as provided in regulations prescribed by the Secretary of Labor.

Subsection (c) provides that a bond shall include the terms and conditions the Secretary considers necessary to protect the Thrift Savings Fund against loss. It also provides that a bond have as surety a corporate surety company which is an acceptable surety on Federal bonds under authority granted by the Secretary of the Treasury and shall be in a form or of a type approved by the Secretary of Labor.

Subsection (d) provides that it shall be unlawful for any person covered by subsection (a) to receive, handle, disburse or exercise custody or control of funds of the Thrift Savings Fund without being bonded. It also provides that it shall be unlawful for any fiduciary or other person with authority to direct the performance of functions in paragraph (1) to permit the performance of such functions by any person who does not meet the bonding requirements as provided in subsection (a).

Subsection (e) provides that a person required to be bonded under subsection (a) shall be exempt from any other provision of law which would require bonding for handling funds or property of the Thrift Savings Fund.

Subsection (f) provides for the Secretary of Labor to prescribe regulations to carry out the provisions of this section and to exempt a person or class of persons from the requirements of this section.

Section 8499. Exculpatory provisions; insurance

Subsection (a) provides that any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability under this subchapter shall be void. Subsection (b) provides for the Executive Director to require agencies to contribute not more than 1 percent of the amount contributed to the Thrift Savings Fund under section 8421(b) to purchase insurance to cover potential liability of persons serving in a fiduciary capacity with respect to the Thrift Savings Fund.

Section 101 (b) amends the table of chapters at the beginning of part III of title 5 to insert after chapter 83 the following:

"84. Federal Retirement System 8401."

TITLE II—AMENDMENTS RELATING TO SOCIAL SECURITY

Section 201 amends section 210(a)(5) of the Social Security Act to cover prospective service performed by an employee who was subject to CSRS who opts to transfer to the FRS.

Section 202 amends section 3121(b)(5) of the Internal Revenue Code of 1954 to tax the wages of an individual described above.

FEDERAL EMPLOYEES' RETIREMENT SYSTEM ACT OF 1986

MAY 16, 1986.—Ordered to be printed

Mr. FORD of Michigan, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 2672]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 2672), to redesignate the New York International and Bulk Mail Center in Jersey City, New Jersey, as the "New Jersey International and Bulk Mail Center", and to honor the memory of a former postal employee by dedicating a portion of a street at the New York International and Bulk Mail Center in Jersey City, New Jersey, as "Michael McDermott Place", having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendments of the Senate numbered 1 and 2, and agree to the same.

That the House recede from its disagreement to the amendment of the Senate numbered 3 and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment, insert the following:

TITLE I—FEDERAL EMPLOYEES' RETIREMENT SYSTEM

SEC. 100. SHORT TITLE; TABLE OF CONTENTS.

(a) ***SHORT TITLE.***—*This Act may be cited as the "Federal Employees' Retirement System Act of 1986".*

(b) ***TABLE OF CONTENTS.***—*The table of contents is as follows:*

TABLE OF CONTENTS

TITLE I—FEDERAL EMPLOYEES' RETIREMENT SYSTEM

Sec. 100. Short title; table of contents.

Sec. 100A. Purposes.

Sec. 101. Establishment.

TITLE II—OTHER AMENDMENTS TO TITLE 5 OF THE UNITED STATES CODE

- Sec. 201. Treatment under Civil Service Retirement System of certain individuals excluded from Federal Employees' Retirement System.*
- Sec. 202. Non-applicability of Civil Service Retirement System to individuals under Federal Employees' Retirement System.*
- Sec. 203. Pay for the Executive Director of the Federal Retirement Thrift Investment Board.*
- Sec. 204. Alternative forms of annuities.*
- Sec. 205. Retirement counseling.*
- Sec. 206. Participation by certain employees and Members only in the Thrift Savings Plan.*
- Sec. 207. Miscellaneous amendments.*

TITLE III—OTHER PROVISIONS RELATING TO THE FEDERAL EMPLOYEES' RETIREMENT SYSTEM AND THE CIVIL SERVICE RETIREMENT SYSTEM

- Sec. 301. Elections.*
- Sec. 302. Effect of an election under section 301 to become subject to the Federal Employees' Retirement System.*
- Sec. 303. Provisions relating to an election to become subject to chapter 83 subject to certain offsets relating to Social Security.*
- Sec. 304. Amendments relating to Social Security.*
- Sec. 305. Extension of Federal Employees' Retirement Contribution Temporary Adjustment Act of 1983; refund of excess contributions.*
- Sec. 306. Applicability to the United States Postal Service.*
- Sec. 307. Use of "normal-cost percentage".*
- Sec. 308. Retirement study.*
- Sec. 309. Repeal of automatic transfer provision.*
- Sec. 310. Disclosure of return information.*
- Sec. 311. Initial appointments to the Federal Retirement Thrift Investment Board.*
- Sec. 312. Plan for delayed contributions to the Thrift Savings Fund.*

TITLE IV—FOREIGN SERVICE RETIREMENT

- Sec. 401. Short title; references to Foreign Service Act of 1980.*
- Sec. 402. Redesignation of certain provisions of the Foreign Service Act of 1980.*
- Sec. 403. Definition of court.*
- Sec. 404. Creditable service for purposes of subchapters I and II.*
- Sec. 405. Contributions to the Foreign Service Retirement and Disability System.*
- Sec. 406. Offset of annuity by the amount of Social Security benefits.*
- Sec. 407. 18-month period to elect survivor annuity.*
- Sec. 408. Alternate forms of annuities.*
- Sec. 409. Treatment of certain recall service.*
- Sec. 410. Reemployment.*
- Sec. 411. Comparability between the Federal Employees' Retirement System and the Foreign Service Pension System.*
- Sec. 412. Moderation of remarriage penalty.*
- Sec. 413. Lump-sum payments.*
- Sec. 414. Exclusion of participants in Foreign Service Pension System from Foreign Service Retirement and Disability System.*
- Sec. 415. Foreign Service Pension System.*
- Sec. 416. Table of contents.*
- Sec. 417. Effective date.*

TITLE V—CENTRAL INTELLIGENCE AGENCY RETIREMENT AND RELATED MATTERS

- Sec. 501. References.*
- Sec. 502. Contributions to the Central Intelligence Agency Retirement and Disability System.*
- Sec. 503. Offset of annuity by the amount of Social Security benefits.*
- Sec. 504. Thrift savings fund participation by participants in the Central Intelligence Agency Retirement and Disability System.*
- Sec. 505. Alternative forms of annuities.*
- Sec. 506. Participation in the Federal Employees' Retirement System.*
- Sec. 507. Special retirement accrual for other intelligence personnel.*

TITLE VI—MISCELLANEOUS PROVISIONS

Sec. 601. Annuities for survivors of District of Columbia judges.

TITLE VII—AUTHORIZATION OF APPROPRIATIONS; EFFECTIVE DATES

Sec. 701. Authorization of appropriations for certain expenses of the Federal Retirement Thrift Investment Management System.

Sec. 702. Effective dates.

SEC. 100A. PURPOSES.

The purposes of this Act are—

- (1) to establish a Federal employees' retirement plan which is coordinated with title II of the Social Security Act;*
- (2) to ensure a fully funded and financially sound retirement benefits plan for Federal employees;*
- (3) to enhance portability of retirement assets earned as an employee of the Federal Government;*
- (4) to provide options for Federal employees with respect to retirement planning;*
- (5) to assist in building a quality career work force in the Federal Government;*
- (6) to encourage Federal employees to increase personal savings for retirement; and*
- (7) to extend financial protection from disability to additional Federal employees and to increase such protection for eligible Federal employees.*

SEC. 101. ESTABLISHMENT.

(a) IN GENERAL.—Title 5, United States Code, is amended by inserting after chapter 83 the following new chapter:

“CHAPTER 84—FEDERAL EMPLOYEES' RETIREMENT SYSTEM

“SUBCHAPTER I—GENERAL PROVISIONS

“Sec.

“8401. Definitions.

“8402. Federal Employees' Retirement System; exclusions.

“8403. Relationship to the Social Security Act.

“SUBCHAPTER II—BASIC ANNUITY

“8410. Eligibility for annuity.

“8411. Creditable service.

“8412. Immediate retirement.

“8413. Deferred retirement.

“8414. Early retirement.

“8415. Computation of basic annuity.

“8416. Survivor reduction for a current spouse.

“8417. Survivor reduction for a former spouse.

“8418. Survivor elections; deposit; offsets.

“8419. Survivor reductions; computation.

“8420. Insurable interest reductions.

“8420a. Alternative forms of annuities.

“8421. Annuity supplement.

“8421a. Reductions on account of earnings from work performed while entitled to an annuity supplement.

“8422. Deductions from pay; contributions for military service.

“8423. Government contributions.

“8424. Lump-sum benefits; designation of beneficiary; order of precedence.

“8425. Mandatory separation.

"SUBCHAPTER III—THRIFT SAVINGS PLAN

- "8431. Definition.
- "8432. Contributions.
- "8433. Benefits and election of benefits.
- "8434. Annuities: methods of payment; election; purchase.
- "8435. Protections for spouses and former spouses.
- "8436. Administrative provisions.
- "8437. Thrift Savings Fund.
- "8438. Investment of Thrift Savings Fund.
- "8439. Accounting and information.
- "8440. Tax treatment of the Thrift Savings Fund.

"SUBCHAPTER IV—SURVIVOR ANNUITIES

- "8441. Definitions.
- "8442. Rights of a widow or widower.
- "8443. Rights of a child.
- "8444. Rights of a named individual with an insurable interest.
- "8445. Rights of a former spouse.

"SUBCHAPTER V—DISABILITY BENEFITS

- "8451. Disability retirement.
- "8452. Computation of disability annuity.
- "8453. Application.
- "8454. Medical examination.
- "8455. Recovery; restoration of earning capacity.
- "8456. Relationship to workers' compensation.
- "8457. Military reserve technicians.

"SUBCHAPTER VI—GENERAL AND ADMINISTRATIVE PROVISIONS

- "8461. Authority of the Office of Personnel Management.
- "8462. Cost-of-living adjustments.
- "8463. Rate of benefits.
- "8464. Commencement and termination of annuities of employees and Members.
- "8465. Waiver, allotment, and assignment of benefits.
- "8466. Application for benefits.
- "8467. Court orders.
- "8468. Annuities and pay on reemployment.
- "8469. Withholding of State income taxes.
- "8470. Exemption from legal process; recovery of payments.

"SUBCHAPTER VII—FEDERAL RETIREMENT THRIFT INVESTMENT MANAGEMENT SYSTEM

- "8471. Definitions.
- "8472. Federal Retirement Thrift Investment Board.
- "8473. Employee Thrift Advisory Council.
- "8474. Executive Director.
- "8475. Investment policies.
- "8476. Administrative provisions.
- "8477. Fiduciary responsibilities; liability and penalties.
- "8478. Bonding.
- "8479. Exculpatory provisions; insurance.

"SUBCHAPTER I—GENERAL PROVISIONS

"§ 8401. Definitions

"For the purpose of this chapter—

"(1) the term 'account' means an account established and maintained under section 8439(a) of this title;

"(2) the term 'annuitant' means a former employee or Member who, on the basis of that individual's service, meets all requirements for title to an annuity under subchapter II or V of this chapter and files claim therefor;

FEDERAL EMPLOYEES' RETIREMENT SYSTEM

TITLE

The Senate amendment entitles the new retirement system the Federal Retirement System.

The House bill has no comparable provision.

The House committee bill entitles the system, the Civil Service Supplemental Retirement System.

The conference agreement entitles the system, the Federal Employees' Retirement System (FERS).

BASIC PLAN

Coverage

The Senate amendment covers all Federal employees (including congressional staff and employees of Gallaudet College) hired, or rehired after a break in service for more than one year, after December 31, 1983. Additionally, all Members of Congress elected or appointed after December 31, 1983, are similarly covered. United States Park Police and the United States Secret Service hired, or rehired after the requisite break in service, after the above date are covered. Nonappropriated fund employees of the Department of Defense hired, or rehired after the requisite break in service, after the above date are covered. Members of the Foreign Service and certain employees of the Central Intelligence Agency (CIA) are covered under special provisions. A special arrangement is provided for those employees and Members of Congress who are covered by both the Civil Service Retirement System (CSRS) and the Social Security Act.

Under the Senate amendment all employees and Members of Congress covered by the CSRS or other related Government retirement programs may transfer into this system during a one-year window period. Employees of the District of Columbia are not covered and are prospectively excluded from CSRS beginning January 1, 1987.

The House bill has no comparable provision.

The House committee bill covers Civil Service employees, including congressional staff and employees of Gallaudet College, hired after December 31, 1983. Coverage is also extended to those employees rehired after the above date with a break in service of more than one year if those employees served less than five years under CSRS. Members of Congress, the Park Police and the Secret Service are also covered. A special arrangement similar to the Senate provision is provided for those employees and Members covered by CSRS and the Social Security act. Employees covered by CSRS may not transfer into the new system. Employees of the District of Columbia are not covered and are prospectively excluded from CSRS beginning October 1, 1987.

The conference agreement adopts the Senate provisions with modifications. Similar to the House committee bill, rehired employees with 5 years or more prior service subject to CSRS retain coverage under a revised CSRS. District of Columbia employees hired after October 1, 1987 are excluded from CSRS. Nonappropriated

fund employees are not covered. Employees under the current retirement system will have six months beginning July 1, 1987, to elect into the new system.

Creditable service

The Senate amendment provides that creditable service includes service in a covered position in the new retirement system, service covered by the Federal Employees' Retirement Contribution Temporary Adjustment Act of 1983, military service, service creditable under CSRS (only for purposes under transition provisions), leaves of absences creditable under CSRS, and unused sick leave.

The House bill has no comparable provision.

The House committee bill provides that creditable service for most individuals includes civilian service subject to social security, military service, service covered by the Federal Employees' Retirement Contribution Temporary Adjustment Act of 1983, leaves of absence without pay while serving in the military or receiving worker's compensation, other leaves of absence of 6 months or less, and certain leaves of absence without pay for full-time service in an employee organization if the cost of such service is fully paid by the employee.

The conference agreement generally adopts the approach of the House committee bill except that a period of post-1956 military service is creditable only if the employee makes a contribution to the retirement fund equal to 3 percent of the employee's military base pay for such period. The conferees decided that the cost of retirement credit for military service should be absorbed, in part, by the employer as is the case under the CSRS. The ratio of the employee contribution for military service (3 percent) to the cost of the defined benefit plan under FERS is comparable to that under CSRS.

The conferees note that under FERS sick leave is not creditable service except for such leave carried into the system by an employee who transfers from CSRS. The conferees urge the Office of Personnel Management to examine the sick leave usage by employees under FERS. The conferees are concerned that without an incentive to save sick leave, the use of sick leave may substantially increase.

One plan

The Senate amendment provides two retirement options. Upon employment employees have 90 days in which to irrevocably choose between the two.

The House bill has no comparable provision, but the House committee bill provides for only one retirement plan.

The conference agreement adopts the House committee approach. The managers agree that, for personnel management and administrative reasons, one plan is preferable. Under FERS employees will have significant flexibility and choice with respect to participation and investment options in the thrift plan.

Vesting

The Senate amendment provides that benefits will vest after five years of civilian service.

The House bill has no comparable provision. The House committee bill also provides that benefits vest after five years of civilian service.

The conference agreement adopts the House committee bill approach, with the qualification that service for which a refund of contributions has been made is irrevocably forfeited as creditable service.

Salary base

The Senate amendment provides a salary base of the average of an employee's five highest consecutive years of salary to determine the retirement benefit.

The House bill has no comparable provision.

The House committee bill provides a salary base of the average of an employee's three highest consecutive years of salary to determine the retirement benefit.

The conference agreement adopts the House committee approach.

Accrual rate

The Senate amendment provides an accrual rate equal to .9 percent for each year of service for the first 15 years and 1.1 percent for each year over 15 years.

The House bill has no comparable provision.

The House Committee bill provides an accrual rate equal to 1 percent for each year of service.

The conference agreement adopts the approach of the House committee bill, except that the accrual rate is 1.1 percent for each year of service if the employee is at least age 62 at the time of retirement and has completed at least 20 years of service.

Employee contributions

The Senate amendment (Option A) does not require employee contributions. Option B requires employees to contribute to the retirement fund an amount based on the difference between the Old Age, Survivor and Disability Insurance (OASDI) tax and the amount the employees would have been required to contribute to CSRS had they been covered under CSRS.

The House bill has no comparable provision.

The House Committee bill requires employees to contribute to the retirement fund an amount based on the difference between the OASDI tax rate and the CSRS contribution rate.

The conference agreement adopts the House committee approach. The conferees wrestled with the question of whether the basic plan should be contributory. Each dollar required as a contribution to the basic plan leaves one dollar less available for investment in the thrift plan. The conferees resolved the dilemma by mandating an employee contribution to the basic plan while at the same time requiring an employer thrift plan contribution which approximates the required employee contribution.

The required employee contributions to the basic plan will be 1.3 percent of basic pay in 1987, 0.94 percent from 1988 to 1990, and 0.8 percent in 1990 and thereafter. This is in addition to the mandatory OASDI tax.

Deferred benefits

The Senate amendment entitles former employees who have sufficient service and who attain the applicable minimum age for immediate retirement to deferred benefits. Under Option A, a former employee is entitled to an unreduced deferred benefit at age 62 with five or more years of service and reduced deferred benefits at age 55 with 10 or more years of service. Option B provides the same benefits and, also, provides unreduced deferred benefits to former employees who attain age 55 with 30 or more years of service.

The House bill has no comparable provision.

The House committee bill provides a deferred benefit to a former employee who attains age 62 with 5 or more years of service.

The conference agreement adopts the Senate approach which entitles a former employee with sufficient service to benefits when he or she attains the requisite minimum age to be eligible for immediate retirement. The agreement provides entitlement to *unreduced* benefits to former employees who attain age 62 with five or more years of service, age 60 with 20 or more years of service and age 55-57 with 30 or more years of service depending upon the year in which the employee retires. *Reduced* benefits are available to a former employee who attains age 55-57 with 10 or more years of service depending upon the year in which the employee retires. Providing deferred benefits to former employees under the same conditions as immediate benefits to current employees is consistent with the requirements of the Employee Retirement Income Security Act (ERISA) as applied to private pension plans. Additionally, this provision increases career flexibility for Federal employees who leave Government prior to becoming eligible for an immediate retirement benefit.

Involuntary retirement

The Senate amendment provides for involuntary retirement under the same conditions as the CSRS, i.e., if an employee is age 50 with at least 20 years of service or at any age with at least 25 years of service. The employee's benefit is reduced 2 percent for each year the employee is under age 62.

The House bill has no comparable provisions.

The House committee bill provides for involuntary retirement under the same conditions and eligibility requirements as the Senate amendment. However, those eligible for benefits would not face a reduction in their annuities based on age at time of retirement.

The conference agreement adopts the House committee approach. An employee removed from Government involuntarily is eligible to receive an immediate and unreduced benefit if the employee is age 50 with at least 20 years of service or any age with at least 25 years of service.

Annuity supplement

The Senate amendment does not include a supplement to the basic pension for those employees retiring before age 62 except

with respect to special class employees, e.g., firefighters, law enforcement officers, and air traffic controllers.

The House bill has no comparable provision.

The House committee bill does include such a supplement for those retiring at age 55 with 30 years of service or age 60 with 20 years of service, as well as for special class employees.

The conference agreement adopts modified version of the House committee provision. The supplement will be paid to those employees who retire at the minimum retirement age (55-57) with at least 30 years of service, those who retire at age 60 with at least 20 years of service, and those involuntarily separated beginning when they attain the minimum retirement age. The supplement is designed to replicate the Social Security benefit (based on Federal civilian service) available at age 62 for those employees retiring earlier. The supplement terminates once the employee attains age eligibility to receive Social Security benefits, i.e., age 62. The provision in the conference agreement differs from the one in the House committee bill in three respects. First, the formula was redesigned to assume that no Social Security benefits were earned in post-Federal employment. Second, the supplement is not adjusted for inflation. Third, the amount of the supplement actually payable is reduced by earnings in excess of a minimum amount, just as the amount of Social Security benefits payable at age 62 are reduced by earnings in excess of that amount. Earnings in excess of the exempt amount in the Social Security Act (the 1986 amount is \$5,760.00 which is wage indexed) will reduce the supplement by one dollar for every two dollars earned. The conferees note that in order to assure continuity of a benefit stream throughout retirement, the supplement is subjected to the same conditions as payment of the Social Security benefit.

Cost-of-living adjustments

The Senate amendment provided for different cost-of-living adjustments (COLAs) for the various benefits depending on the retirement plan option selected. Under Option A, annuitants would receive no COLAs until age 62. For annuitants aged 62 through 66 and for those receiving disability or survivor benefits, the COLA would equal the percentage increase in the Consumer Price Index (CPI) minus two percentage points. At age 67, all COLAs would equal the actual percentage increase in the CPI.

Under Option B of the Senate amendment, annuitants up to age 62 would receive a COLA equal to the percentage increase in the CPI minus 2 percentage points. For annuitants at age 62 and above and for survivors and those disabled at any age the COLA would be the full CPI increase.

The House bill has no comparable provision.

The House committee bill provides for full COLAs for retirees, survivors, and disability annuitants.

Except in the case of special classes of employees, discussed below, the conference agreement provides for no COLA for retirees under age 62. For retirees age 62 and over, and for those receiving disability or survivor benefits regardless of age, the COLA is generally equal to the percentage increase in the CPI minus one percentage point. In those years for which the percentage increase in the

mendation of the Speaker of the House, one on recommendation of the Senate Majority Leader, and the final one upon recommendation of the other four. The Board sets overall policy, which is administered by an executive director and a support staff. The Chairman appoints a 14 member Employee Thrift Advisory Council representing labor, management, women, and retiree organizations. One member is designated by the Chairman as head of the Council and appointments are for four years. The Council advises the Board on investment and administration of the Thrift Savings Fund. The Secretary of Labor is responsible for enforcing fiduciary responsibilities similar to those required by ERISA.

The conference agreement generally adopts the House committee provisions. Board appointees must be confirmed by the Senate with the exception of those appointed for the first term. Unlike most of the rest of the retirement plan, the Thrift Management System is effective upon date of enactment to ensure that the system will be operable when thrift plan participation begins on January 1, 1987. As a result the conference agreement empowers the President to appoint the first panel of Board members for a one year term without Senate confirmation. Subsequent appointments are subject to Senate confirmation. In addition, while the Senate and House will each make a recommendation for appointment, the President need only take such a recommendation into consideration for such an appointment. With regard to advisory groups, the conferees decided that the requirement for Board members and the Executive Director to have substantial expertise in managing financial investments and pension benefit programs would obviate the need for advice from a committee of private sector experts.

SURVIVOR BENEFITS

Preretirement Death

The Senate amendment (Option A) provides a preretirement death benefit to a survivor equal to 50 percent of the accrued retirement benefit of the employee subject to applicable early retirement reductions. Option B provides a benefit equal to 50 percent of the unreduced retirement benefits. A minimum benefit is provided under both options, based on 10 years of service. Option B also provides enhanced life insurance until retirement. Benefits are payable to survivors of vested employees who separated prior to death. Benefits vest after 18 months of service.

The House bill has no comparable provision.

The House committee bill provides a benefit equal to 50 percent of the accrued annuity of the employee where Social Security is payable. If Social Security is not payable, the benefit is the lesser of (a) the current CSRS benefit or (b) 50 percent of the accrued annuity, plus a Social Security supplement. Benefits vest after 18 months of service.

The conference agreement provides a surviving spouse a lump sum payment of \$15,000 (indexed to CPI) plus one-half of the employee's annual rate of pay or high-3 average pay if higher. The spouse may elect the lump sum to be paid as an annuity or to be paid out over a shorter period. In addition, the surviving spouse receives an annuity equal to 50 percent of the employee's accrued un-

reduced annuity if the deceased employee had 10 years of service. Benefits vest after 18 months of service. Benefits are payable to survivors of vested employees who separated prior to death.

To the extent practical, the conference agreement reflects survivor benefit practice. Private industry uses a mixture of life insurance and survivor annuities. These coupled with Social Security survivor benefits generally provide adequate benefits. The conferees considered using a combination of insurance and annuities but found this approach would require significant changes in the Federal Employees Group Life Insurance (FEGLI) program. The conferees were not prepared to address significant changes in FEGLI at this time. Instead, the conference agreement approximates private sector insurance practice by providing an option of a lump sum payment. This should improve the ability of survivors to meet the financial demands resulting from the loss of a spouse. As a result of these survivor provisions, basic life insurance coverage may be redundant in some circumstances. The conferees urge the Office of Personnel Management to immediately study the impact of these provisions on FEGLI and recommend appropriate changes to the basic life insurance program.

Postretirement death

Both options under the Senate amendment require a 10 percent "survivor" reduction in the basic annuity to provide post retirement survivor benefits. A joint waiver is required for alternate annuity forms. Under Option A the survivor is entitled to 50 percent of the retiree's annuity, including any early retirement reductions. If the survivor predeceases the annuitant, the survivor reduction is not restored. Under Option B the survivor is entitled to 50 percent of the accrued annuity without early retirement reductions. If the survivor predeceases the annuitant, the survivor reduction is restored.

The House bill has no comparable provision.

The House committee bill requires a survivor reduction equivalent to that required under CSRS. This reduction is made unless the retiree and spouse jointly waive the survivor option. If Social Security is payable, the benefit is equal to 50 percent of the retiree's unreduced annuity. If Social Security is not payable, the benefit is the lesser of (1) the current CSRS benefit or (2) 50 percent of the retiree's unreduced annuity plus a Social Security supplement payable until Social Security eligibility. If the survivor predeceases the annuitant, the survivor reduction is eliminated.

The conference agreement requires a survivor reduction of 10 percent (absent a joint waiver). The remainder of the provisions are adopted from the House committee bill.

Children's benefits

The Senate amendment has no provision.

The House bill has no provision.

The House committee bill provides children's benefits equivalent to those under the current CSRS offset by any Social Security benefits payable.

The conference agreement adopts the House committee approach.

DISABILITY BENEFITS

The Senate amendment establishes a separate long-term disability (LTD) insurance plan which pays benefits to a disabled employee with at least 18 months of service after the employee has used all sick leave. A totally disabled employee receives 60 percent of average salary offset by 100 percent of the Social Security benefit if any. For an individual who does not meet the Social Security disability definition, but who is disabled for his or her occupation, the benefit decreases to 40 percent of average salary after the first year. The benefit continues until the individual recovers or is converted to the regular retirement rolls. Occupationally disabled individuals are converted at age 55 and the totally disabled at age 62.

Time spent on the disability rolls is credited as service for purposes of the basic retirement benefit formula. In addition, the employee's salary at onset of disability is adjusted upward to the time of conversion. While receiving benefits, individuals are subject to medical examinations and to reviews of earnings. The portion of the disability benefit cost which comes from the LTD plan is paid by agencies to a newly established Federal Employee's Disability Insurance Fund. Benefit payments are made by a third party administrator.

The House bill has no comparable provision.

Under the House committee bill an employee who completes at least 5 years of creditable civilian service and is found by OPM to be unable to perform the duties of such employee's position will be eligible for disability retirement and an annuity. The disability annuity will be equal to the employee's accrued retirement benefit but will be no less than the smaller of (1) 20 percent of the employee's average pay, or (2) an annuity computed under the regular annuity formula after projecting the employee's service to age 60. Disabled employees who are unable to perform the duties of their positions but who do not qualify for benefits under the stricter Social Security definition of disability will be entitled to receive an annuity supplement to make up for the lack of Social Security benefits.

The conference agreement includes provisions from both the Senate amendment and the House Committee bill. Like the House committee bill, the disability benefit will be paid as an annuity from the retirement fund. The conference agreement adopted the Senate provision regarding eligibility for benefits after 18 months of service. The amount of the benefit during the first year is 60 percent of average pay minus 100 percent of any Social Security benefit payable. After the first year, the benefit for the occupationally disabled is 40 percent of average pay. For the totally disabled a 40 percent of average pay disability benefit is offset by 60 percent of the Social Security benefit payable. Total income flowing from both the disability benefit and Social Security will range from approximately 58 percent of average pay for the low income down to 46 percent for the higher income.

At age 62 the annuity is recomputed and the annuitant will receive the lesser of the total disability benefit (regardless of the extent of the disability) or a recomputed retirement benefit. For the retirement recomputation, years spent on disability are counted as years of service and average pay is increased by the cost of

living adjustments applicable to disability annuities during the period of disability.

The disability benefit is particularly complex due to the need to coordinate with Social Security benefit computation formulas and disability criteria. The Social Security definition of disability is a very strict definition. Both bills provide and the conferees concur that payment of benefits is warranted where an employee is disabled for his position (occupationally disabled) but does not qualify for Social Security benefits. As a consequence, two categories of disabled employees receive benefits. In both cases a reasonable benefit is necessary, but the benefit payable to the Social Security disabled must take into account the amount of the Social Security benefit to avoid being overly compensated. Thus, one recipient receives a benefit only from the plan while the other receives it from the plan and Social Security.

The tilt to lower-income employees in total disability cases results from the tilt to lower-income employees in the Social Security benefit formula. The offset formula utilized for the totally disabled flattens the tilt somewhat.

Conversion to retirement benefits, if lower, at age 62 is necessary to assure that the disabled person does not receive greater benefits in his retired years than the one who voluntarily retired from active employment. Finally, at the time of conversion, the occupationally disabled individual is deemed to receive the total disability amount for conversion purposes to prevent the occupationally disabled from receiving more in total income than the totally disabled, once old age benefits commence from Social Security.

TRANSFERS FROM CSRS TO THE FERS

The Senate amendment permits individuals covered by the CSRS, including those covered by both Social Security and CSRS, to elect to join the new plan within one year after the effective date, which is January 1, 1987. Rules which apply in the case of a transfer include:

(1) Service both before and after the transfer counts for eligibility to retire.

(2) Increases in average salary after the transfer apply to benefit computations under both plans.

(3) Survivor benefits come from both plans.

(4) Disability coverage under CSRS stops and the employee gets credit for service before the transfer toward the 18 months needed to become eligible for long term disability benefits under the new plan.

(5) Service before the transfer counts for vesting in the Government's share of contributions to the thrift plan.

(6) Employees who transfer and remain in the new plan for five years are no longer subject to the windfall benefit reduction or the public pension offset rule applying to spouses under the Social Security Act.

The House bill and the House committee bill have no comparable provision.

The conference agreement adopts the Senate amendment approach, (with the exception of item six above) and permits employ-

ees under CSRS to transfer into the new system. Generally, an election to transfer may not be made prior to July 1, 1987, nor after December 31, 1987.

Individuals covered by CSRS only may transfer to the new plan. Those individuals covered by CSRS on December 31, 1983, but who were subsequently covered by Social Security may transfer into the new plan. Those individuals who performed 5 years of civilian service creditable under CSRS, who separated and who later were rehired subject to Social Security may transfer into the new plan during the later of the six-month period following reemployment or the six-month election period described above. Reemployed annuitants retired under CSRS may transfer into the new plan.

Rules applicable to transfer regarding creditability of service, vesting, average pay, and disability benefits are essentially the same as under the Senate amendment. New rules include:

(1) Military service performed before the effective date of the transfer generally is not creditable under FERS except in determining eligibility for benefits.

(2) Cost-of-living adjustments for the portion of the annuity earned before the transfer will be under the CSRS formula; the portion earned after the transfer will be under the FERS formula. COLAs for children's benefits will be under the FERS formula.

(3) Sick leave credited as service for benefit computation purposes under CSRS will be the number of days credited at the time of transfer or the date of retirement, whichever is less.

(4) A supplement for retirees with 30 years of service who are between age 55 and 62 is computed on service after the date of the transfer.

(5) A transfer election is effective with the first pay period beginning after the date of election and is irrevocable.

(6) An individual who elects to transfer and who has a former spouse entitled to CSRS benefits based on a court order or court-approved property settlement must have the written consent of the former spouse before the election can be effective.

(7) Service in CSRS is counted for purposes of survivor benefits under FERS. Survivor benefits are paid only under FERS.

The conferees agreed that individuals with at least 5 years creditable service in CSRS who return after more than a one year break in service should retain entitlement to CSRS benefits unless they elect to be covered by FERS benefits.

Finally, the conference agreement provides that anyone who transfers into the new plan will be covered by Social Security prospectively.

INTERIM EMPLOYEES

The Senate amendment provides that individuals hired or rehired after 1983 and who were covered by the Federal Employees' Retirement Contribution Temporary Adjustment Act of 1983 receive service credit in the new plan beginning on the date of such hiring or rehiring. CSRS retirement contributions made by these individuals, together with a Government contribution and interest on both, are used to establish a thrift savings account for the individual.

The House bill has no comparable provision.

The House committee bill provides that (1) individuals covered by both CSRS and Social Security, and (2) individuals reemployed after more than a one year break in service who have at least five years of civilian service covered by CSRS are credited under the CSRS with covered interim service without additional deposit requirements. These individuals remain under revised CSRS benefit and contribution formulas.

Employees hired during the interim period or rehired with less than 5 years service are given service credit in the new plan for all service under CSRS or the interim system, without regard to deposit requirements.

The conference agreement essentially adopts the provisions of the House committee bill relating to individuals covered by both CSRS and Social Security and those individuals vested in CSRS and rehired during the interim period. They remain under CSRS under revised benefit and contribution formulas. Those employees hired during the interim period or rehired with less than 5 years civilian service are given service credit in the new plan but an appropriate deposit is required if that service is not covered by contributions. In addition, the Government will deposit in the Thrift Savings Fund on behalf of those employees 1 percent of basic pay paid during periods of employment under the interim system (with interest).

TREATMENT OF CERTAIN INDIVIDUALS COVERED UNDER CSRS AND SOCIAL SECURITY

The Senate amendment provides that individuals employed continuously since December 31, 1983, who were covered by Social Security, retain coverage under CSRS under a revised formula. These employees include Members of Congress and political appointees at the Senior Executive Service level and above.

The House committee bill provided similar treatment for those employees covered by the Senate amendment as well as employees rehired subject to Social Security who were vested in CSRS.

The conference agreement adopts the House provisions. The affected employees will be covered under both CSRS and Social Security. They will pay the full OASDI tax and a reduced contribution to the Civil Service Retirement Fund. The reduced contribution will be an amount equal to the difference between the full CSRS contribution applicable to the covered employee and OASDI tax.

These employees will be entitled to full Social Security benefits and a reduced Civil Service annuity. The Civil Service annuity will be reduced by the amount of the Social Security benefit attributable to Federal service.

Service during the interim period is creditable in the same manner. Employees who contributed the full CSRS amount during the interim period will be refunded the difference between the amount they contributed and the offset amount. Those employees who were permitted to make full contributions to both plans may continue to do so, thereby avoiding the offset provisions.

EXTENSION OF FEDERAL EMPLOYEES' RETIREMENT CONTRIBUTION TEMPORARY ADJUSTMENT ACT OF 1983

The Senate amendment extends the provisions of the Act until January 1, 1987, thereby extending the interim retirement system until that date.

Neither the House bill nor the House committee bill has a comparable provision.

The Federal Employees' Retirement Contribution Temporary Adjustment Act of 1983, as enacted, was to expire on December 31, 1985. Its life was extended until April 30, 1986, by section 147 of Public Law 99-190. The Act did expire on April 30 thereby requiring increased retirement contributions by those Federal employees subject to Social Security.

The conference agreement retroactively extends the Act from April 30, 1986, until December 31, 1986, at which time the new Federal Employees' Retirement System takes effect. It further authorizes refunds of excess retirement contributions required between April 30, 1986, and the date of the enactment of the conference agreement.

AUTHORIZATION, APPLICATION, AND EFFECTIVE DATES

The Senate amendment provides for payment of the fiscal year 1986 and 1987 expenses of the Federal Retirement Thrift Investment Board for appropriations, authorizes a \$1 million appropriation for OPM to perform required informational activities, and makes the FERS effective January 1, 1987, except for the thrift management system, which is effective on date of enactment, and the thrift loan program, which must be established by January 1, 1988.

The House bill has no comparable provision.

The House committee bill has provisions comparable to the Senate amendment regarding payment of thrift fund administrative start up costs and effective dates. It does not authorize an appropriation for informational activities. It provides that for purposes of the first cost-of-living adjustment under the new retirement system, the base quarter ending on September 30, 1986, shall be considered to have been the base quarter for a year in which a cost-of-living adjustment under such system was made.

The conference agreement adopts the House committee bill provisions.

DISCLOSURE OF RETURN INFORMATION

Under current law, section 6103 of the Internal Revenue Code provides that income tax returns and return information shall be confidential except for certain limited cases specifically set forth in that section.

The Senate amendment provides that the Office of Personnel Management shall have access to any information in the possession of any government agency that is necessary for administration of the retirement system.

The conference agreement provides that the Commissioner of Social Security will disclose to the Office of Personnel Management

return information concerning net earnings from self-employment, wages, and payments of retirement income that have been disclosed to the Social Security Administration (SSA) under IRC section 6103. Only that information which is strictly necessary for the administration of the retirement system as provided in chapters 83 and 84 of title 5, United States Code may be disclosed under this section, and only according to written agreement between SSA and OPM, with such consultation with the Department of the Treasury as may be necessary.

The conference agreement also provides for reimbursement to the Social Security Administration (through the Department of Health and Human Services) for the costs of providing return information, as well as for the costs of providing any other information, such as hypothetical benefit computations, that may be required under agreements between Social Security Administration and the Office of Personnel Management.

FOREIGN SERVICE RETIREMENT

Title IV of the bill establishes a Foreign Service Pension System (FSPS) to provide retirement benefits for members of the Foreign Service appointed after 1983. FSPS parallels the Federal Employees' Retirement System (FERS) established by Title I of the bill for newly appointed Civil Service employees.

Members of the Foreign Service who are or who become participants in FSPS are made subject to all the provisions in chapter 84 of title 5, United States Code. Code (FERS) unless specifically provided otherwise in title IV of the bill. Different treatment for the Foreign Service is provided to permit continued operation of its special personnel system with its up-or-out and rank-in person rather than rank-in-position features and continued administration of the system by the Secretary of State. The special features incorporated in the FSPS are comparable to the special features in the FERS for personnel also eligible for age 50 retirement such as law enforcement, firefighter and air traffic controller personnel.

SENATE AMENDMENT

The Senate amendment established a Foreign Service Pension System (FSPS). The new System would provide retirement benefits for members appointed after 1983, and is very similar to the Federal Employees' Retirement System (FERS) established by the bill for new appointees in the Civil Service after 1983. All Foreign Service members who become participants in the FSPS would be subject to all provisions of the comparable FERS unless specifically provided otherwise by law. All the exceptions are stated in the Senate amendment.

The Foreign Service (FS) has always had its own retirement system separate from the Civil Service Retirement System. The basic reason for this is that the FS needs special provisions for early retirement to permit operation of its up-or-out personnel system. A number of FS members are mandatorily retired every year to permit advancement of the more competitive and most able personnel. This system was endorsed and expanded by the Foreign

Service Act of 1980. The special provisions are also necessary to permit the early retirement of members who, for various reasons, are no longer able to serve abroad after completing a career in dangerous and difficult environments.

The FSPS proposed in the Senate amendment would preserve the early retirement and other special features needed by the FS. It would permit members to retire voluntarily at age 50 with 20 or more years of service with the same benefit as provided for special category personnel such as law enforcement, firefighter, and air traffic controller personnel. The system would permit FS members who are retired mandatorily at an early age to receive the "mid-tier" benefit based on high-5 salary without penalty for early retirement. The third basic special provision would provide an annuity supplement equivalent to a Social Security benefit from the date of retirement to age 62 when the annuitant would be eligible for the actual Social Security benefit. This annuity supplement would be based on all creditable service.

A detailed analysis of the Senate amendment follows:

Title V of the Senate amendment consisted of 7 sections:

Section 501 amends chapter 8 of the FSA of 1980 which contains the authority for the existing Foreign Service Retirement and Disability System (FSRDS), to designate the existing portion as "Subchapter I" and to make conforming amendments to change the word "chapter" wherever it appears in chapter 8 to "subchapter", and "act" to "subchapter" in certain cases.

Section 502 amends section 805 of the Foreign Service Act of 1908, relating to deductions from a participant's pay for Foreign Service Retirement and Disability System (FSRDS) coverage. An employee who was covered by the FSRDS on December 31, 1983, and who was subsequently covered by Social Security will continue in the FSRDS at a reduced contribution. The contribution to FSRDS will be equal to the excess of the employee's normal FSRDS contribution over the OASDI portion of the Social Security tax.

Section 503 amends section 806 to require that annuities of retirees and survivors under the current FSRDS who are entitled to Social Security benefits for Federal service have their annuities reduced at age 62 in a manner comparable to the amendment to 5 U.S.C. 8339(o) made by the Senate amendment.

Section 504 amends existing section 823 which deals with retirement benefits of retired FS members who are recalled to active duty. The amendment provides that members who are recalled in the future and whose recall service comes under the new FS Pension System will receive the same benefits as reemployed annuitants.

Section 505 restates existing section 834 which concerns reemployed annuitants. The FS has long had a distinctive rule on reemployed annuitants to permit use of retired members who are uniquely qualified to perform certain essential tasks. This amendment recognizes that some reemployed annuitants will have an annuity under both the new and old systems. It also recognizes that it would be difficult or inappropriate to recompute a FS annuity following employment under the new Federal Employees' Retirement System. Accordingly, the amendment proposes, in such situations, to provide an additional annuity computed under Subchapter B,

based on salary and service during reemployment in lieu of recomputation. Section 506 amends section 827 to extend the existing "Executive Order" procedure for maintaining conformity between the CS and FS retirement systems to the new FERS and FSPS.

Section 507 is the major substantive amendment. It establishes as subchapter II of chapter 8 of the Foreign Service Act of 1980, the FSPS. Section 851 of the new subchapter provides that participants in the new FSPS shall be subject to all provisions in chapter 84 of title 5, United States Code governing FERS except where otherwise specifically provided by law.

Section 852 provides definitions of the following terms: Annuity, dynamic assumption, Fund, normal cost, participant, supplemental liability, and System.

Section 853 provides that all members of the FS whose service after 1983 brings them under Social Security and who would, save for this section, be participants in the FSRDS, shall be participants in the FSPS.

Section 854 provides special rules governing entitlement to annuity under FSPS. Any entitlement or requirement not mentioned here would automatically, pursuant to section 851, be governed by chapter 84 of title 5, United States Code.

Subsection 854(a) provides that members retiring voluntarily or mandatorily under the conditions of existing sections 607, 608, 811 or 813 receive an annuity computed under proposed new section 8413 applicable to "special category" personnel in the Civil Service.

Subsection 854(b) provides that those retired under subsection (a) above, will be entitled to an annuity supplement from the effective date of retirement to age 62 based on total creditable service of the member and computed under section 8413(b) of title 5.

Subsection 854(c) makes participants in the new system subject to existing provisions for voluntary and mandatory retirement of existing sections 811, 812 and 813.

Subsection 854(d) carries forward to the new system the provision denying pension benefits to a member separated on grounds of disloyalty to the United States.

Section 855 along with the definition of "Fund" in section 852 provide that all monies to finance the System shall be paid into the existing Foreign Service Retirement Fund and benefits paid out of that fund. Financing arrangements would exactly parallel those for the FERS, except that the Department of Treasury would provide actuarial services for the FSPS, as at present with respect to the FSRDS.

Section 856 provides that the Secretary of State in consultation with the Medical Director of the Foreign Service, rather than an administrator of benefits under chapter 84, of title 5, United States Code, shall make determinations of disability as affected by fitness for overseas service for purposes of subchapter V of such chapter 84.

Section 857 provides that the Secretary of State shall administer the FSPS exclusive of matters pertaining to Disability and the Thrift Savings Plan. These would be administered in accordance with subchapters II, V and VIII, chapter 84 of title 5, United States Code, except as provided in section 856, as explained above.

Section 858 provides for transition from the old system to the new. The transition provisions are comparable to those applicable to CSRS employees.

Section 859 provides that references in certain paragraphs of the Senate amendment to participation in the Federal Employees' Retirement System shall be deemed to include participation in the Foreign Service Pension system.

CONFERENCE AGREEMENT

Title IV of the conference agreement follows the Senate amendment with minor or conforming changes except that provisions under title I relating to law enforcement officers are generally applicable and except as noted below:

Definition of court

Section 403 of the conference agreement revises the definition of "court" in the Foreign Service Act to make it comparable to the definition added to chapter 83 of title 5 by P.L. 98-615. The revised definition permits the recognition of orders by territorial and Indian courts affecting the payment of retirement and survivor benefits to former spouses.

18-month period to elect survivor annuity

Section 407 of the conference agreement amends the Foreign Service Act to grant annuitants under the existing Foreign Service Retirement and Disability System an 18-month grace period to elect or increase a survivor benefit for a spouse to whom married at retirement. This amendment is comparable to an amendment of chapter 83 of title 5 by P.L. 99-251.

Alternate forms of annuities

Section 408 of the conference agreement amends the Foreign Service Act to provide participants in the existing Foreign Service Retirement and Disability System alternate forms of annuities actuarially equivalent to whole life annuities now provided. This amendment is comparable to the amendment to chapter 83 of title 5 made by section 204 of the conference agreement.

Moderation of remarriage penalty

Section 412 of the conference agreement amends the Foreign Service Act retroactively to November 8, 1984 to moderate the remarriage penalty affecting former spouses, surviving spouses and former spouses of members of the Foreign Service. The amendment permits continuation of benefits or retention of entitlement to benefits if a remarriage occurs on or after age 55 rather than age 60 as at present. The amendment is comparable to the amendment made to chapter 83 of title 5 by P.L. 98-615 effective November 8, 1984.

Former spouses

Sections 861 and 862 being added to the Foreign Service Act by section 415 of the conference agreement as a part of the new Foreign Service Pension System conform that System with existing provisions on former spouses added to the Foreign Service Retirement System.

ment and Disabilities System by the landmark Foreign Service Act of 1980. These sections do two basic things: first, with respect to certain former spouses, section 861 mandates a pro-rata share division of retirement and survivor benefits when a different distribution has not been ordered or approved by a court or agreed to by the parties. Secondly, section 862 authorizes a participant in the new System to "contract" with his or her spouse or former spouse on a mutually agreed upon distribution of benefits under the System. The purpose of section 862 is to allow the parties to arrange for a mutually agreed upon distribution of retirement benefits without going to court.

Section 861 would apply only to a former spouse married to a participant during 10 years of creditable service with at least 5 of those years occurring while the participant was an active member of the Foreign Service. This is comparable to the 10-year marriage requirement now in chapter 8 of the Foreign Service Act. Distributions under the Foreign Service Pension System to former spouses other than pro-rata share distributions under section 861 will be governed by provisions in chapter 84 of title 5 applicable to former spouses of employees under the Federal Employees' Retirement System. Those benefits will be available to former spouses as defined in that chapter: married 9 months to an individual with 18 months of civilian service credit.

Subsection 861(d) covers the situation where a member becomes entitled to benefits under both the Foreign Service Retirement and Disability System and the Foreign Service Pension System and has a former spouse at the time of transfer to the latter System. In the common situation where benefits are apportioned pursuant to a court order or spousal agreement, the intent may be to provide a pro-rata share distribution but the language of the instrument may base the share on length of the marriage during service creditable only under the Retirement System, and not under the Pension System. This will provide an especially large share of the Retirement System benefits. If such an order or spousal agreement is not amended, it would not be fair to provide, under this section, an additional pro-rata share of pension system benefits to the former spouse. The purpose of subsection (d) is to prohibit this possibility.

Similarly, in the case where a former spouse is entitled to a pro-rata share of Retirement System benefits based on years married during the entire Government career, it would be unfair not to provide the former spouse the same share of Pension System benefits. Subsection (d) serves this purpose. A related amendment is made to existing sections of the Act by section 404 of the conference agreement. The purpose is to assure that two former spouses married for the same period to members who have identical careers, one of whom transfers to the new Pension System and the other remains under the old Retirement System, will each receive the same share of benefits under this chapter, if payments are based on pro rata share distributions.

CENTRAL INTELLIGENCE AGENCY RETIREMENT

Title V of the conference agreement addresses federal employee retirement benefits for officers and employees of the Central Intelligence Agency (CIA). One section of Title V also addresses a related matter involving very limited numbers of National Security Agency (NSA) employees and Defense Intelligence Agency (DIA) employees.

After enactment of the Federal Employees' Retirement System Act of 1986, employees of the Central Intelligence Agency will generally fall into four basic categories, each with differing retirement benefits and obligations:

(1) *CSRS participants*.—Most Central Intelligence Agency employees whose federal service began before December 31, 1983 participate in the Civil Service Retirement System maintained under subchapter III of chapter 83 of title 5, United States Code. These CIA employees enjoy the same benefits as federal employees in other agencies who participate in the Civil Service Retirement System.

(2) *CIARDS participants*.—In 1964, Congress enacted the Central Intelligence Agency Retirement Act of 1964 for Certain Employees (50 U.S.C. 403 note) to establish a CIA Retirement and Disability System (CIARDS) for CIA employees whose duties are "(i) in support of Agency activities abroad hazardous to life or health or (ii) so specialized because of security requirements as to be clearly distinguishable from normal government employment" (Sec. 203 CIA, Retirement Act). The CIA employees participating in the CIARDS receive retirement benefits superior to those provided generally by the CSRS, benefitting in particular from a higher annual pension accrual rate and an option for early retirement. The group of CIARDS participants will consist of CIA employees whose federal service began prior to December 31, 1983 who are, or who will become eligible (whether before, on or after December 31, 1983), to participate in CIARDS in accordance with the CIA Retirement Act and implementing regulations.

(3) *FERS regular participants*.—Central Intelligence Agency employees whose federal service began after December 31, 1983 will participate in the Federal Employees' Retirement System (FERS) established under the new chapter 84 of title 5, United States Code. Unless they fall within the special category of CIA employees who qualify for FERS treatment equivalent to that accorded law enforcement officers, the CIA employees covered by the FERS will incur the same obligations and receive the same benefits as do most federal employees covered by the FERS.

(4) *FERS section 203 criteria participants*.—The CIA employees whose federal service began after December 31, 1983 (and who therefore participate in the FERS) and who meet the criteria prescribed under section 203 of the CIA Retirement Act, namely that their CIA duties are "(i) in support of Agency activities abroad hazardous to life or health or (ii) so specialized because of security requirements as to be clearly distinguishable from normal government employment," will incur the same obligations and receive the same benefits as do federal employees covered by the FERS who are law enforcement officers. The FERS accords preferential bene-

fits to law enforcement officers in comparison to most other types of federal employees, and thus CIA's FERS section 203 criteria participants will receive preferential benefits in comparison to CIA FERS regular participants.

The conferees agreed that, to improve the security of intelligence sources, methods and activities, the CIA should administer all federal retirement systems as they apply to CIA officers and employees. The conference agreement provides for such CIA administration. Providing for CIA administration of retirement systems as they apply to CIA employees reduces unnecessary dissemination within the government of intelligence personnel information, improving security. The administration of the retirement systems by CIA as to CIA employees will not differ substantively from OPM administration of such systems with respect to other federal employees. The benefits and obligations of CIA employees and non-CIA employees within a retirement system will not differ; only the agencies administering the system as to those employees will differ. As a result of provisions of the conference agreement providing for CIA administration of the CSRS and the FERS with respect to CIA employees, all aspects of retirement system administration with regard to CIA employees will remain completely within the CIA, except for Merit Systems Protection Board and federal court review of certain adverse retirement decisions made by the DCI with respect to CIA CSRS and regular FERS employees. The conferees expect the MSPB and the federal courts to conduct such proceedings in a manner consistent with the protection of intelligence sources, methods and activities. The conferees also expect close cooperation among OPM, the Executive Director of the Thrift Investment Board, and the DCI to ensure both uniform administration of federal retirement systems and the protection of intelligence sources, method and activities, particularly as the conference agreement provides for OPM and Executive Director, Thrift Investment Board inspection and audit of CIA-related disbursements from the Civil Service Retirement and Disability Fund and the Thrift Savings Plan.

The DCI must submit all retirement regulations he issues to the intelligence committees of the Congress before the regulations take effect.

SECTION-BY-SECTION EXPLANATION

Title V of the conference agreement addresses Central Intelligence Agency retirement and related matters. Title V consists of sections 501 through 506 amending the Central Intelligence Agency Retirement Act of 1964 for Certain Employees and title 5 of the United States Code and section 507 making related changes.

Section 501: References

Section 501 of the conference agreement amends the CIA Retirement Act of 1964.

Section 501(1) amends section 201(c) of the CIA Retirement Act to make clear that the provisions of section 201(c), which provide for the finality and unreviewability of DCI administration of the CIA Retirement Act, do not override the provision of section 305(d) of

the CIA Retirement Act (added by section 506 of the conference agreement) which permits CIA regular FERS employees to appeal certain adverse retirement determinations made by the DCI to the Merit Systems Protection Board and the federal courts in accordance with section 8461(e) of title 5 (as added by section 101 of the conference agreement).

Section 501(2) replaces the phrase "this Act" each place it appears in Title II of the CIA Retirement Act with the phrase "this title" (except in two specified sections), which is necessitated by the addition of a new Title III to the CIA Retirement Act by section 506 of the conference agreement.

Section 501(3) inserts the phrase "under this title" in Title II of the CIA Retirement Act after the phrase "payable from the fund" (meaning the CIA Retirement and Disability Fund) each place it appears in the title, which is necessitated by the addition of a new Title III to the CIA Retirement Act by section 506 of the conference agreement.

Section 502: Contributions to the CIA retirement and disability system

Section 502 of the conference agreement amends section 211 of the CIA Retirement Act of 1964.

Section 502(1) amends section 211 of the CIA Retirement Act to provide for an exception from the CIARDS contribution requirement of seven percent of basic salary contained in section 211(a) for participants described in new section 211(d) of the CIA Retirement Act as added by section 502(2) of the conference agreement.

Section 502(2) adds to section 211 of the CIA Retirement Act a new subsection (d) providing for contributions to the CIA Retirement and Disability Fund by CIARDS participants subject to title II of the CIA Retirement Act before January 1, 1984, whose service is employment for purposes of Title II of the Social Security Act and the social security tax provisions of the Internal Revenue Code but whose service is not creditable service under the new Federal Employee Retirement System. Such individuals would be CIARDS annuitants (who were participants before January 1, 1984) who are recalled to service after a one year break in service, political appointees, or individuals described in section 301(c)(1) of the CIA Retirement Act. The conferees intend that this provision not apply to any individuals other than individuals who fall within one of these categories. The contribution due to the CIA Retirement and Disability Fund from such an individual is equal to seven percent of basic pay, less the amount of social security taxes deducted and withheld from basic pay.

Section 503: Offset of annuity by amount of social security benefits

Section 503 of the conference agreement amends section 221 of the CIA Retirement Act of 1964 by adding a new section 221(p). Section 221(p) provides that the annuity payable under CIARDS to an individual described in section 301(c)(1) of the CIA Retirement Act (as added by section 506 of the conference agreement) shall be offset by the amount of the individual's Social Security benefits, in the manner provided by section 8349 of title 5, United States Code (as added by section 201(b) of the conference agreement). An indi-

vidual described in section 301(c)(1) of the CIA Retirement Act is one who separates, or has separated, from federal service after having been a CIA employee subject to CIARDS and having completed at least 5 years of civilian service creditable under CIARDS. The social security offset under subsection 221(p) does not apply to the annuity of an individual described in section 301(c)(1) who has elected to participate in the new FERS.

Section 504: Thrift Savings Fund participation by participants in the CIARDS

Section 504 of the conference agreement adds a new section 293 to the CIA Retirement Act of 1964. Section 293 permits CIARDS participants to remain in CIARDS and to elect to participate in the Thrift Savings Plan on the same basis as CSRS participants may remain in the CSRS and elect to participate in the Thrift Savings Plan under section 8351 of title 5, United States Code (as added by the conference agreement). Sections 8461 (k) and (m) of title 5, United States Code (as added by the conference agreement) apply with respect to contributions to the Thrift Savings Plan, and resultant earnings, by CIA employees who have elected, while remaining in the CIARDS or the CSRS, to participate in the Thrift Savings Plan. This ensures that the DCI will handle all administration with respect to CIARDS and CSRS participants who have elected to participate in the Thrift Savings Plan.

Section 505: Alternative forms of annuities

Section 505 of the conference agreement add a new section 294 to the CIA Retirement Act of 1964 to authorize the DCI to provide by regulation for alternative forms of annuities for CIARDS participants to elect upon retirement. To the maximum extent practicable, the regulations and the alternative forms of annuities must meet the requirements prescribed in section 8343a of title 5, United States Code (as added by the conference agreement). The DCI must submit the regulations to the intelligence committees of the Congress before they take effect.

Section 506: Participation in the Federal Employees' Retirement System

Section 506 of the conference agreement enacts a new Title III of the CIA Retirement Act of 1964 for Certain Employees, consisting of sections 301-307.

Section 301 of the CIA Retirement Act provides for application to certain CIA employees of the Federal Employee Retirement System established under chapter 84 of title 5, United States Code (as added by section 101 of the conference agreement).

Section 301(a) provides that the FERS applies to all Agency personnel any of whose service after December 31, 1983 is employment for purposes of Title II of the Social Security Act and the social security tax provisions of the Internal Revenue Code, except as provided in subsections 301 (b) and (c).

Section 301(b) provides that CIARDS participants who were CIARDS participants on or before December 31, 1983, and who have not had a one year break in service then, are not subject to

the FERS, without regard to whether they are subject to Title II of the Social Security Act.

Section 301(c) provides that the FERS does not apply to an individual who separates, or has separated, from federal service after having been a CIA employee subject to CIARDS and having completed at least 5 years of civilian service creditable under CIARDS, unless the individual elects to become subject to the FERS.

Section 301(d) provides that the provisions of chapter 84 of title 5 (as added by section 101 of the conference agreement), which establishes the FERS, apply to CIA employees covered by the FERS, subject to any exceptions and special rules provided in Title III of the CIA Retirement Act with respect to such CIA employees.

Section 302 of the CIA Retirement Act provides special rules for CIA FERS section 203 criteria employees.

Section 302(a) provides that CIA employees subject to the FERS who are designated by the DCI under the criteria prescribed in section 203 of the CIA Retirement Act shall be treated for purposes of their retirement benefits and obligations under the FERS as if they were law enforcement officers as defined in section 8401(17) of title 5, United States Code (as added by section 101 of the conference agreement). The conferees emphasize that CIA personnel are not law enforcement officers, and indeed, are prohibited by section 102(d)(3) of the National Security Act from exercising law enforcement powers (except for CIA Security Protection Service personnel who have law enforcement powers under section 15 of the CIA Act of 1949 within CIA installations). The CIA FERS section 203 criteria employees are merely to be treated as if they were law enforcement officers for purposes of determining their FERS retirement benefits and obligations. The criteria of section 203 of the CIA Retirement Act to which the section refers permit designation of CIA FERS employees for retirement treatment equivalent to law enforcement officers if the CIA employees' duties are "(i) in support of Agency activities abroad hazardous to life or health or (ii) so specialized because of security requirements as to be clearly distinguishable from normal government employment."

Section 302(b) provides that the voluntary retirement provisions applicable to CIARDS participants under section 233 of the CIA Retirement Act also apply to CIA FERS section 203 criteria employees and that the mandatory retirement provisions applicable to CIARDS participants under section 235 of the CIA Retirement Act also apply to CIA FERS section 203 criteria employees, except that the applicable retirement benefits are those specified for such special category employees under the FERS in chapter 84 of title 5, United States Code. Section 233 of the CIA Retirement Act permits voluntary retirement by an employee who is at least 50 years of age and has rendered 20 years of service provided the employee has not less than ten years of Agency service, of which at least five years shall have been service after designation, or shall have been service prior to designation consisting of duties meeting the criteria prescribed in section 203 of the CIA Retirement Act. Section 235 of the CIA Retirement Act permits mandatory retirement of a designated employee who has completed at least 25 years of service, or who has completed 20 years of service and is at least 50 years of age, provided such employee has not less than ten years of Agency

service, of which at least five years shall have been service after designation, or shall have been service prior to designation consisting of duties meeting the criteria prescribed in section 203 of the CIA Retirement Act. Section 235 also provides for automatic separation from the Agency at age 60 of a section 203-designated Agency employee receiving compensation at less than the GS-18 level and for automatic separation of such an employee at age 65 if such employee is receiving compensation at the GS-18 level or above, subject to extensions by up to a total of five years by the DCI when it is in the public interest. A section 203-designated Agency employee who is automatically separated at age 60 or 65 receives retirement benefits under the applicable retirement system if the employee has completed five years of Agency service.

Section 302(c) provides that the recall provisions applicable to CIARDS participants under section 271 of the CIA Retirement Act also apply to CIA FERS section 203 criteria employees, except that a CIA FERS section 203 criteria employee make contributions during recall service as provided in section 8422 of title 5, United States Code (as added by section 101 of the conference agreement). When a CIA FERS section 203 criteria employee recalled to service subsequently reverts to a retired status, his FERS annuity is re-determined.

Section 303 provides a special rule for use in determining the FERS annuity of a retiring CIA employee who is not a FERS section 203 criteria employee and who has served outside the United States during his Agency service. The portion of such annuity relating to service abroad performed by such employee after the effective date of the Federal Employees' Retirement System Act of 1986 is based on the higher accrual rate set forth in section 8415(d) of title 5, United States Code (as added by section 101 of the conference agreement), while the portion of the annuity of such employee relating to other service is based on the normal FERS accrual rate applicable to that employee's other service. The conferees provided the accrual rate increase for periods of service abroad for regular CIA FERS employees because such employees, during their service abroad, perform work substantially similar to that of FERS section 203 criteria employees, and should thus enjoy equivalent pension accrual rights during that period as a matter of equity.

Section 304 provides special rules relating to certain former spouses of certain CIA personnel. The conferees' intention is to preserve the existing regime of benefits for former spouses of CIA personnel, subject to necessary technical changes. The term "former spouse," as defined in the CIA Retirement Act (section 204(b)(4)) incorporates the requirement, applicable throughout the new Title III of the CIA Retirement Act that, to be considered a "former spouse," the former wife or husband of a CIA employee must have been married to the CIA employee for not less than 10 years of Agency service, at least 5 years of which were spent outside the United States by both the employee and the spouse (the "10/5 requirement"). As a result of section 304, CIA FERS employees' former spouses, who meet the 10/5 requirement, receive former spouses benefits analogous to those received by CIA CIARDS and CSRS employees' former spouses who met the 10/5 requirement. Throughout the discussion below of this section, unless the context

indicates otherwise, the term "former spouse" when used in reference to a CIA employee's former spouse, means only a former wife or husband who satisfies the 10/5 requirement.

Section 304(a) provides that the former spouse provisions in chapter 84 of title 5, United States Code (as added by section 101 of the conference agreement) do not apply to a CIA FERS employee who has a former spouse meeting the 10/5 requirement. Instead, the special rules provided in section 304 apply to such an employee and former spouse. For a CIA FERS employee whose former spouse did not meet the 10/5 requirement, the normal former spouses provisions of chapter 84 of title 5 (as added by section 101 of the conference agreement) would apply.

Section 304(b) provides that the provision in section 221(b)(1)(C) of the CIA Retirement Act for a joint employee/former spouse waiver of a survivor annuity by spousal agreement applies with respect to the survivor annuity for a CIA FERS employee's former spouse under section 304(c)(2).

Section 304(c) provides that certain specified provisions of the CIA Retirement Act of 1964 relating to CIA CIARDS employees apply equally to CIA FERS employees with respect to former spouses. The specified provisions made applicable deal with computation of annuities for former spouses, election of survivor benefits for former spouses, sharing of discontinued service (i.e., lump sum) benefits with former spouses, and the effect of payments under spousal agreements or court orders.

Section 304(d) provides technical special rules with respect to computation of annuities for CIA FERS employees' spouses in accordance with section 222(a) of the CIA Retirement Act as made applicable by subsection 304(c). The special rules are necessary to take account of the recall and reemployment situations of CIA FERS employees and to take account that CIA FERS employees' contributions belong in the Civil Service Retirement and Disability Fund rather than the CIA Retirement and Disability fund to which CIA CIARDS participants contribute.

Section 304(e) provides special rules relating to the survivor annuities of CIA FERS employees' former spouses under subsections (b) and (c) of section 222 of the CIA Retirement Act as made applicable by section 304(c). The special rules adjust the application of the CIA Retirement Act provisions made applicable to CIA FERS former spouses provisions in light of the former spouses provisions of chapter 84 of title 5, United States Code (as added by section 101 of the conference agreement) with respect to percentage of employee annuity used in calculating former spouse survivor benefits, the employee annuity base used in such calculation, survivor annuity election, aggregation of multiple survivor annuities, and employee contributions to fund elected survivor annuities.

Section 304(f) provides for computation of the reduction of a CIA FERS employee's annuity to provide survivor annuities in the manner provided by section 8419(a) of title 5, United States Code (as added by section 101 of the conference agreement).

Section 304(g) provides that the entitlement of a retired CIA FERS employee's former spouse to a portion of the employee's annuity extends to any annuity supplement the employee receives

under section 8421 of title 5, United States Code (as added by section 101 of the conference agreement).

Section 305 provides that section 201(c) of the CIA Retirement Act, which provides for the finality and unreviewability of DCI administration of the CIA Retirement Act, applies to administration of FERS by the CIA with respect to CIA employees, except that regular CIA FERS employees may appeal certain adverse retirement decisions made by the DCI to the Merit Systems Protection Board and the federal courts as provided in section 8461(e) of title 5, United States Code (as added by section 101 of the conference agreement). Subsection 8347(n) of title 5, United States Code (as amended by the conference agreement) contains a provision similar with respect to finality and unreviewability of DCI administration of the CSRS with respect to CIA employees and similar with respect to appeals of certain DCI decisions by CIA CSRS employees.

Section 306 authorizes the DCI to prescribe in regulations (in consultation with the Director, OPM and the Executive Director of the Thrift Investment Board) appropriate procedures to carry out Title III of the CIA Retirement Act. The DCI must submit the regulations to the intelligence committees of the Congress before the regulations take effect.

Section 307 authorizes the DCI to provide by regulation for the transition from CIARDS to FERS for CIARDS participants electing to participate in the FERS. Section 307 gives CIA CIARDS employees the same opportunity to elect to participate in the FERS as CIA CSRS employees enjoy under title III of the Federal Employee's Retirement System Act of 1986. The DCI must submit the regulations implementing section 307 to the intelligence committees of the Congress before the regulations take effect.

Section 507: Special retirement accrual for other intelligence personnel

Section 507 extends, to a limited number of civilian employees of the National Security Agency and the Defense Intelligence Agency covered by the CSRS and the FERS, the special retirement accrual benefit provided to CIA regular FERS employee for periods of overseas service by section 303 of the CIA Retirement Act (as added by section 506 of the conference agreement). The conferees concluded that NAS and DIA civilian employees within the groups covered by section 9(b)(1)(B) of the NSA Act of 1959 and section 1605(a) of Title 10, United States Code merit treatment equivalent to that afforded CIA regular FERS employees for periods of service abroad because of the nature of their intelligence duties.

ADMINISTRATION OF CSRS AND FERS FOR EMPLOYEES OF THE CIA

Section 206(i) of the conference agreement amends section 8347 of title 5, United States Code, to add a new subsection 8347(n) to provide for CIA administration of the Civil Service Retirement System as it applies to CIA employees. Section 8347(n) provides for CIA administration of the CSRS as it applies to CIA employees in the same way as section 8461 of title 5, United States Code (as amended by the conference agreement) provides for CIA administration of the FERS as it applies to CIA employees. The conferees

concluded that CIA administration with respect to CIA employees of all retirement systems applicable to CIA employees forms an essential part of efforts to improve the protection afforded to intelligence sources, methods and activities.

These provisions (sections 8347 and 8461) provide that the Director of Central Intelligence may, consistent with the administration of CSRS and FERS by the Office of Personnel Management and the Executive Director of the Federal Retirement Thrift Investment Board and to the extent the DCI considers appropriate, administer CSRS and FERS retirement provisions as they apply to CIA personnel. In addition the DCI may, to the extent he considers appropriate, perform with respect to CIA personnel the functions and duties (including with respect to disbursements from the Civil Service Retirement Fund or the Thrift Savings Plan, but not including Thrift Savings Plan investment decisions) of the Director, OPM or the Executive Director, Thrift Investment Board under subchapter III of chapter 83 or under chapter 84, which those officers would otherwise perform. To the extent that the DCI does not exercise his authority to assume the functions and duties of OPM or the Executive Director with respect to CIA CSRS and FERS employees, OPM and the Executive Director would continue to perform such functions and duties with respect to CIA CSRS and FERS employees. Allowing the DCI to assume such functions and duties to the extent he considers appropriate will permit a phased, orderly assumption of retirement administration functions and duties by the CIA.

These provisions also provide that sections 8439(b), 8461(h)(1), and 8474(c)(4) of title 5, United States Code (as added by section 101 of the conference agreement) shall be applied with respect to information relating to CIA personnel in a manner that protect intelligence sources, methods and activities. Section 8439(b) relates to auditing of the Thrift Savings Plan by a qualified public accountant and a report to the General Accounting Office. Section 8461(h)(1) relates to OPM access to information held by other agencies. Section 8474(c)(4) relates to Executive Director, Thrift Investment Board access to information held by other agencies. Although nothing in the Federal Employees' Retirement System Act of 1986, or the amendments made by the Act, impairs or affects statutes (such as section 102(d)(3) of the National Security Act of 1947 and sections 6 and 8 of the CIA Act of 1949) and Executive Orders (such as Executive Orders 12333 governing intelligence activities and 12356 governing national security information) regarding protection of intelligence sources, methods and activities, the conferees believed it appropriate to emphasize the requirement for such protection because certain provisions of chapter 84 refer specifically and address the issue of access by one agency to information held by another agency. Security practices, including clearance requirements, normally applicable to intelligence information will apply in the administration of sections 8439(b), 8461(h)(1) and 8474(c)(4) of title 5 as they are applied with respect to CIA.

From the Committee on Post Office and Civil Service:

For consideration of the Senate amendments Nos. 1, 2, and 3 and modifications committed to conference:

WILLIAM D. FORD,
WILLIAM CLAY,
MARY ROSE OAKAR,
GENE TAYLOR,
JOHN T. MYERS,

As additional conferees on Senate Amendment No. 3:

From the Permanent Select Committee on Intelligence:

For consideration of title IV of the Senate amendment and modifications committed to conference:

LEE H. HAMILTON,
LOUIS STOKES,
ANTHONY C. BEILENSON,
BOB STUMP,
ANDY IRELAND,

As additional conferees on Senate Amendment No. 3:

From the Committee on Foreign Affairs:

For consideration of title V of the Senate amendment and modifications committed to conference:

DANIEL A. MICA,
PETER H. KOSTMAYER,
OLYMPIA SNOWE,

As additional conferees on Senate Amendment No. 3:

From the Committee on Ways and Means:

For consideration of provisions in section 101 of the Senate amendment establishing a new subchapter III of chapter 84—Thrift Savings Plan; establishing a new section 8475 in subchapter VII—transition provisions; of title II of the Senate amendment; and of section 305 of the Senate amendment and modifications committed to conference:

BILL ARCHER,
WM. THOMAS,
Managers on the Part of the House.

W.V. ROTH, Jr.,
TED STEVENS,
CHARLES MCC. MATHIAS, Jr.,
TOM EAGLETON,
ALBERT GORE, Jr.,
Managers on the Part of the Senate.



FEDERAL EMPLOYEES' RETIREMENT SYSTEM ACT OF 1986

MAY 16, 1986.—Ordered to be printed

Filed, under authority of the order of the Senate of MAY 15 (legislative day,
MAY 12), 1986

Mr. ROTH, from the Committee of Conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 2672]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 2672), to redesignate the New York International and Bulk Mail Center in Jersey City, New Jersey, as the "New Jersey International and Bulk Mail Center", and to honor the memory of a former postal employee by dedicating a portion of a street at the New York International and Bulk Mail Center in Jersey City, New Jersey, as "Michael McDermott Place", having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendments of the Senate numbered 1 and 2, and agree to the same.

That the House recede from its disagreement to the amendment of the Senate numbered 3 and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment, insert the following:

TITLE I—FEDERAL EMPLOYEES' RETIREMENT SYSTEM

SEC. 100. SHORT TITLE; TABLE OF CONTENTS.

(a) *SHORT TITLE.*—This Act may be cited as the "Federal Employees' Retirement System Act of 1986".

(b) *TABLE OF CONTENTS.*—The table of contents is as follows:

TABLE OF CONTENTS

TITLE I—FEDERAL EMPLOYEES' RETIREMENT SYSTEM

Sec. 100. Short title; table of contents.

Sec. 100A. Purposes.

Sec. 101. Establishment.

This report is identical to H.C.R. 99-606.

Finder's Aid
P.L. 99-349 (100 Stat. 710) Approved July 2, 1986
Urgent Supplemental Appropriations Act, 1986

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-510</u>	<u>S.Rep. 99-301</u>	<u>H.C.Rep. 99-649</u>
Medicare - Inpatient Hospital Services - Capital- Related Costs - Moratorium	1886(a)(4)	206	749	—	88	77
Medicare - Inpatient Hospital Services - Capital- Related Costs - Moratorium	1886(g)(1)	206	749	—	88	77



PUBLIC LAW 99-349—JULY 2, 1986

**URGENT SUPPLEMENTAL
APPROPRIATIONS ACT, 1986**

Public Law 99-349
99th Congress

An Act

July 2, 1986

[H.R. 4515]

Making urgent supplemental appropriations for the fiscal year ending September 30, 1986, and for other purposes.

Urgent
Supplemental
Appropriations
Act, 1986.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the fiscal year ending September 30, 1986, and for other purposes, namely:

TITLE I

GENERAL SUPPLEMENTALS

CHAPTER I

DEPARTMENT OF AGRICULTURE

SOIL CONSERVATION SERVICE

WATERSHED AND FLOOD PREVENTION OPERATIONS

For an additional amount, for emergency measures under title IV of the Agricultural Credit Act of 1978 (16 U.S.C. 2201-2205), \$36,700,000, to remain available until expended.

AGRICULTURAL STABILIZATION AND CONSERVATION SERVICE

EMERGENCY CONSERVATION PROGRAM

For an additional amount, for necessary expenses to carry out the program authorized under title IV of the Agricultural Credit Act of 1978 (16 U.S.C. 2201-2205), \$5,000,000, to remain available until expended.

FOOD SAFETY AND INSPECTION SERVICE

For an additional amount, for "Food Safety and Inspection Service", to protect public health and safety in meat and poultry inspection operations and to meet workload increases resulting from the opening of new or expansion of existing processing plants, \$3,700,000.

PACKERS AND STOCKYARDS ADMINISTRATION

7 USC 181.

For necessary expenses for the administration of the Packers and Stockyards Act, and for certifying procedures used to protect purchasers of farm products, as authorized by law, \$80,000.

DAIRY INDEMNITY PROGRAM

7 USC 450j-450l.

For an additional amount, for "Dairy Indemnity Program", authorized by the Act of August 13, 1968 (82 Stat. 750), the Act of

bined Federal Campaign other than repromulgating and implementing the 1984 and 1985 Combined Federal Campaign regulations, unless such regulations provide that any charitable organization which participated in any prior campaign shall be allowed to participate in the 1986 campaign.

SEC. 205. No part of any appropriation contained in this Act shall remain available for obligation beyond the current fiscal year unless expressly so provided herein.

SEC. 206. Subsections (a)(4) and (g)(1) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) are amended by striking "1986" each place it appears and inserting "1987".

SEC. 207. Notwithstanding section 514 of Public Law 99-178, amounts appropriated by that Act for Federal financial assistance to the Trust Territory of the Pacific Islands shall be available, as would have been available had the Compact of Free Association Act (Public Law 99-239) not been enacted, until alternative funding is available under the terms of the Compact of Free Association Act of 1985 (Public Law 99-239). Thereafter, except insofar as the Compact of Free Association Act otherwise provides, such amounts shall be available only for the Republic of Palau, but only in amounts that such Republic would have received had the Compact of Free Association Act of 1985 not been enacted.

SEC. 208. No funds appropriated or made available under this or any other Act shall be used by the executive branch for soliciting proposals, preparing or reviewing studies or drafting proposals designed to transfer out of Federal ownership, management or control in whole or in part the facilities and functions of the Federal power marketing administrations located within the contiguous 48 States, and the Tennessee Valley Authority, until such activities have been specifically authorized and in accordance with terms and conditions established by an Act of Congress hereafter enacted: *Provided*, That this provision shall not apply to the authority granted under section 2(e) of the Bonneville Project Act of 1937; or to the authority of the Tennessee Valley Authority pursuant to any law under which it may transfer facilities or functions in the normal course of business in carrying out the purposes of the Tennessee Valley Authority Act of 1933, as amended; or to the authority of the Administrator of the General Services Administration pursuant to the Federal Property and Administrative Service Act of 1949, as amended, and the Surplus Property Act of 1944 to sell or otherwise dispose of surplus property.

SEC. 209. None of the funds appropriated by this or any other Act to carry out chapter 1 of part I of the Foreign Assistance Act of 1961 shall be available for any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training in connection with the growth or production in a foreign country of an agricultural commodity for export which would compete with a similar commodity grown or produced in the United States: *Provided*, That this section shall not prohibit (1) activities designed to increase food security in developing countries where such activities will not have a significant impact on the export of agricultural commodities of the United States; or (2) research activities intended primarily to benefit American producers.

SEC. 210. Notwithstanding any other provision of law—

(1) no reduction in the amount of funds for which the City of New York, New York, is eligible under any Federal law, or to

Ante, p. 160.

99 Stat. 1134.
Trust Territory of
the
Pacific Islands.

48 USC 1681
note.

Republic of
Palau.

Energy.
Tennessee
Valley
Authority.

16 USC 832a.

16 USC 831.

40 USC 471
note.
50 USC app. 1622,
1641.
18 USC 3287.
Agriculture and
agricultural
commodities.
Exports.
22 USC 2151.

New York.

which the City of New York, New York, is entitled under any Federal law, may be made, and

(2) no other penalty may be imposed by the Federal Government

by reason of the application of New York City Local Law 19 of 1985 to any contract entered into by the City of New York before October 1, 1986, which is funded in whole, or in part, with funds provided by the Federal Government.

This Act may be cited as the "Urgent Supplemental Appropriations Act, 1986".

Approved July 2, 1986.

LEGISLATIVE HISTORY—H.R. 4515:

HOUSE REPORTS: No. 99-510 (Comm. on Appropriations) and No. 99-649 (Comm. of Conference).

SENATE REPORTS: No. 99-301 (Comm. on Appropriations).

CONGRESSIONAL RECORD, Vol. 132 (1986):

May 8, considered and passed House.

June 5, 6, considered and passed Senate, amended.

June 24, House agreed to conference report; receded and concurred in certain Senate amendments, in others with amendments, and insisted on disagreement to certain amendments.

June 26, Senate agreed to conference report, receded and concurred in certain House amendments, in another with an amendment; House disagreed to Senate amendment, Senate receded from amendment.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 22 (1986):

July 2, Presidential statement.

URGENT SUPPLEMENTAL APPROPRIATIONS BILL, 1986

MARCH 25, 1986.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. WHITTEN, from the Committee on Appropriations,
submitted the following

REPORT

together with

ADDITIONAL VIEWS

[To accompany H.R. 4515]

The Committee on Appropriations submits the following report in explanation of the accompanying bill making urgent supplemental appropriations for the fiscal year ending September 30, 1986.

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No material re Social Security in this report.

URGENT SUPPLEMENTAL APPROPRIATIONS BILL, 1986

MAY 15 (legislative day, MAY 12), 1986.—Ordered to be printed

Mr. HATFIELD, from the Committee on Appropriations,
submitted the following

REPORT

[To accompany H.R. 4515]

The Committee on Appropriations, to which was referred the bill (H.R. 4515) making urgent supplemental appropriations for the fiscal year 1986, and for other purposes, reports the same to the Senate with various amendments and with the recommendation that the bill be passed.

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existence of all Job Corps centers regardless of efficiency and effectiveness, the Committee believes this issue should be kept open for discussion in conference with the House.

GENERAL PROVISIONS

MEDICARE CAPITAL COST MORATORIUM

The Committee has deleted House bill language (sec. 206) which extends the exclusion of reimbursement for hospitals' capital related costs from the medicare prospective payment system from October 1, 1986, to October 1, 1987. The House language was added by floor amendment. Although the Committee is sympathetic to the merits of the amendment, the Committee feels that this matter should be addressed by the authorizing committees.

TRUST TERRITORY OF THE PACIFIC ISLANDS

The Committee has included bill language (sec. 207) to restore funding to certain programs within the Trust Territory of the Pacific Islands that was inadvertently discontinued as the result of a provision in the regular fiscal 1986 Labor-HHS-Education appropriations legislation (sec. 514 of Public Law 99-178). It is the Committee's intention that all programs available to the Trust Territory of the Pacific Islands prior to enactment of Public Law 99-239 (the Compact of Free Association Act of 1985) shall continue to be available to these Micronesian governments (Federated States of Micronesia and the Marshall Islands) until the Compact Act is fully implemented and alternative funding is provided for these programs.

Once Public Law 99-239 is fully implemented, amounts appropriated by Public Law 99-178 for Federal financial assistance to the Trust Territory of the Pacific Islands shall be available only to the Republic of Palau, in amounts that such republic would have received had the compact not been implemented, except that agencies receiving funds under Public Law 99-178 shall continue those programs in the Marshall Islands and the Federated States of Micronesia which are identified for continuation under the terms of the Compact of Free Association Act (Public Law 99-239).

The Committee requests a report by July 15, 1986, for all of the agencies under the jurisdiction of the Labor-HHS-Education Appropriations Subcommittee enumerating which programs are expected to be incorporated into the block grant under the Interior Subcommittee and which programs are expected to be continued with Labor-HHS-Education funding.

SERVICE CONTRACT ACT

The Committee recommends bill language under title II, general provisions (sec. 208) which would amend section 7 of the Service Contract Act of 1965 by including aviation services performed entirely in the State of Alaska in the activities which are exempt from the provisions of the act.

MAKING URGENT SUPPLEMENTAL APPROPRIATIONS FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1986, AND FOR OTHER PURPOSES

JUNE 19, 1986.—Ordered to be printed

Mr. WHITTEN, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.R. 4515]

The committee of conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.R. 4515) making urgent supplemental appropriations for the fiscal year ending September 30, 1986, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its amendments numbered 4, 6, 26, 27, 38, 41, 76, 82, 83, 90, 105, 106, 116, 117, 123, 124, 137, 146, 151, 161, 164, 169, 178, 181, 185, 193, 200, 201, 202, 203, 204, 205, 215, 217, 219, 223, and 224.

That the House recede from its disagreement to the amendments of the Senate numbered 1, 2, 5, 7, 8, 12, 14, 17, 37, 43, 46, 51, 52, 53, 56, 57, 61, 62, 65, 72, 75, 85, 89, 92, 100, 102, 110, 115, 118, 119, 121, 126, 141, 142, 148, 149, 150, 152, 157, 177, 195, 196, 197, 209, 212, 213, and 220, and agree to the same.

Amendment numbered 3:

That the House recede from its disagreement to the amendment of the Senate numbered 3, and agree to the same with an amendment, as follows:

Restore the matter stricken by said amendment amended as follows:

In lieu of the sum named insert: \$5,000,000; and the Senate agree to the same.

Amendment numbered 13:

That the House recede from its disagreement to the amendment of the Senate numbered 13, and agree to the same with an amendment, as follows:

The managers take this section without prejudice to court cases on the provisions of the Gramm-Rudman-Hollings legislation.

Amendment No. 215: Deletes the Senate provision directing the Secretary of the Treasury to invest moneys payable to States and other localities from programs administered by the Secretaries of Agriculture and the Interior and sequestered pursuant to Section 252 of Public Law 99-177 (Gramm-Rudman-Hollings), but not cancelled under Section 256(a)(2) of that Act, in interest-bearing debt instruments, such interest to be payable along with the reserved funds when such funds are released for payment. The House-passed bill had no similar provision.

The managers agree that the sequestered funds should be released for payment within 30 days after the end of the fiscal year, so that the affected States and localities may use the funds without further delay.

INDIRECT COST OF RESEARCH

Amendment No. 216: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the Senate amendment, with an amendment as follows:

In lieu of the matter stricken by said amendment insert the following:

SEC. 203. None of the funds in this Act, or any other Appropriations Act for fiscal year 1986, may be used to implement changes to OMB Circular A-21 made subsequent to February 11, 1986: Provided, That this provision shall expire 60 days after the date of enactment of this Act.

The managers on the part of the Senate will move to concur in the amendment of the House to the amendment of the Senate.

It is the conferees' intention that the OMB should work with the universities to resolve this issue within the time provided.

MEDICARE CAPITAL COSTS

Amendment No. 217: Restores language inserted by the House but deleted by the Senate which extends from September 30, 1986 until September 30, 1987 the moratorium period during which the Department of Health and Human Services is prohibited from including the cost of capital in the Medicare prospective payment system.

COMPACT OF FREE ASSOCIATION

Amendment No. 218: Reported in technical disagreement. The managers on the part of the House will offer a motion to recede and concur in the amendment of the Senate with an amendment to read as follows:

In lieu of the matter proposed by said amendment insert the following:

SEC. 207. Notwithstanding section 514 of Public Law 99-178, amounts appropriated by that Act for Federal financial assistance to the Trust Territory of the Pacific Islands shall be available, as would have been available had the Compact of Free Association Act

Finder's Aid
P.L. 99-500 and 591* (100 Stat. 1783 and 3341) Approved October 18, 1986 and
October 30, 1986 respectively
[Continuing Appropriations - Fiscal Year 1987]

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>S.Rep. 99-500</u>	<u>H.C.Rep. 99-1005</u>
AFDC - Work Incentive Demonstration Program - Deadline for State Application	445(b)(1)	150(a)	1783-352 3341-355	--	790
AFDC - Work Incentive Demonstration Program - Duration of the Program	445(d)	150(b)	1783-352 3341-355	--	790

* Note: For purposes of this Legislative History P.L. 99-500 and P.L. 99-591 are identical. (See the note at the bottom of 100 Stat. 3341-388 for an explanation by the President as to why the two laws were approved.)



* Public Law 99-500
99th Congress

Joint Resolution

Making continuing appropriations for the fiscal year 1987, and for other purposes.

Oct. 18, 1986
[H.J. Res. 738]

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are hereby appropriated, out of any money in the Treasury not otherwise appropriated, and out of applicable corporate or other revenues, receipts, and funds, for the several departments, agencies, corporations, and other organizational units of the Government for the fiscal year 1987, and for other purposes, namely:

SEC. 101. (a) Such amounts as may be necessary for programs, projects or activities provided for in the Agriculture, Rural Development, and Related Agencies Appropriations Act, 1987, at a rate of operations and to the extent and in the manner provided as follows, to be effective as if it had been enacted into law as the regular appropriations Act:

AN ACT

Making appropriations for Agriculture, Rural Development, and Related Agencies programs for the fiscal year ending September 30, 1987, and for other purposes.

TITLE I—AGRICULTURAL PROGRAMS

PRODUCTION, PROCESSING AND MARKETING

OFFICE OF THE SECRETARY

For necessary expenses of the Office of the Secretary of Agriculture, including not to exceed \$75,000 for employment under 5 U.S.C. 3109, \$1,623,000: *Provided*, That not to exceed \$8,000 of this amount shall be available for official reception and representation expenses, not otherwise provided for, as determined by the Secretary.

OFFICE OF THE ASSISTANT SECRETARY FOR ADMINISTRATION

For necessary expenses of the Office of the Assistant Secretary for Administration to carry out the programs funded in this Act, \$455,000.

RENTAL PAYMENTS (USDA)

(INCLUDING TRANSFERS OF FUNDS)

For payment of space rental and related costs pursuant to Public Law 92-313 for programs and activities of the Department of Agriculture which are included in this Act, \$48,728,000: *Provided*, That in the event an agency within the Department of Agriculture should require modification of space needs, the Secretary of Agriculture may transfer a share of that agency's appropriation made available

*Note: This is a subsequently typeset print of the hand enrollment which was signed by the President on October 18, 1986.

See also Public Law 99-591 (100 Stat. 3341) and related Presidential statement (100 Stat. 3341-388).

I-75 corridor in Kenton County, Kentucky, to examine the feasibility of unmanned radar units for safety purposes.

SEC. 149. Notwithstanding any other provision of law or this joint resolution, assistance to Bolivia shall be provided in accordance with the provisions of the Anti-Drug Abuse Act of 1986, as passed by the Senate on September 30, 1986.

SEC. 150. (a) Section 445(b)(1) of the Social Security Act is amended by striking out "June 30, 1985," and inserting in lieu thereof "June 30, 1987,".

(b) Section 445(d) of such Act is amended by striking out "June 30, 1984," and inserting in lieu thereof "June 30, 1987," and by striking out "June 30, 1987" and inserting in lieu thereof "June 30, 1988".

SEC. 151. (a) Notwithstanding any other provision of law, the Administrator of General Services is authorized during fiscal year 1987 to accept periodic reimbursement from the Senate and from the House of Representatives for the cost of any equipment purchased for the Senate or the House of Representatives, respectively, with funds from the General Supply Fund established under section 109 of the Federal Property and Administrative Services Act of 1949. The amount of each such periodic reimbursement shall be computed by amortizing the total cost of each item of equipment over the useful life of the equipment, as determined by the Administrator, in consultation with the Sergeant at Arms and Doorkeeper of the Senate or the Clerk of the House of Representatives, as appropriate.

(b) Subsection (a) applies to reimbursements to the General Supply Fund for any equipment purchased for the Senate or the House of Representatives before, on, or after the date of enactment of this section.

SEC. 152. Section 107D(c)(1)(E)(ii) of the Agricultural Act of 1949 (7 U.S.C. 1445b-3(c)(1)(E)(ii)) is amended by striking out "marketing year for such crop" and inserting in lieu thereof "first 5 months of the marketing year for the 1986 crop and the marketing year for each of the 1987 through 1990 crops".

SEC. 153. (a) The Congress finds that the activities conducted under the authorities of the Foreign Assistance Act of 1961 have contributed greatly to the alleviation of human suffering and the promotion of economic development in the recipient countries. The Congress finds further that changing circumstances in the developing countries and changing availability of resources from the United States require that a comprehensive review of the activities under that Act be undertaken.

(b) It is, therefore, the sense of the Congress that the President should undertake a comprehensive review of the activities authorized by the Foreign Assistance Act of 1961 and should send to the Committees on Appropriations and to the Senate Foreign Relations Committee and the House Foreign Affairs Committee by February 1, 1987, his recommendations for amending the Act or otherwise modifying those activities.

SEC. 154. (a) Section 502(a) of title 21 of the District of Columbia Code is amended by striking out the last sentence and inserting in lieu thereof "Eight of the members of the Commission shall be health care professionals who are psychiatrists, or doctoral level psychologists, practicing in the District of Columbia who have had not less than five years' experience in the treatment of mental illnesses."

(b) Section 502(c) of title 21 of the District of Columbia Code is amended to read as follows:

(1) **HIGH DENSITY RULE.**—The Administrator may not increase the number of instrument flight rule takeoffs and landings authorized for air carriers by the High Density Rule (14 C.F.R. 93.121 et seq.) at Washington National Airport on the date of the enactment of this title and may not decrease the number of such takeoffs and landings except for reasons of safety.

(2) **ANNUAL PASSENGER LIMITATIONS.**—The Federal Aviation Administration air traffic regulation entitled "Modification of Allocation: Washington National Airport" (14 C.F.R. 93.124) shall cease to be in effect on the date of the enactment of this title.

SEC. 6010. AUTHORITY TO NEGOTIATE EXTENSION OF LEASE.

The Secretary and the Airports Authority may at any time negotiate an extension of the lease entered into under section 6005(a).

SEC. 6011. SEPARABILITY.

Except as provided in section 6007(h), if any provision of this title or the application thereof to any person or circumstance, is held invalid, the remainder of this title and the application of such provision to other persons or circumstances shall not be affected thereby.

SEC. 6012. NONSTOP FLIGHTS.

PERIMETER RULE.—An air carrier may not operate an aircraft nonstop in air transportation between Washington National Airport and another airport that is more than 1,250 statute miles away from Washington National Airport.

Approved October 18, 1986.

LEGISLATIVE HISTORY—H.J. Res. 738 (H.R. 5052) (H.R. 5161) (H.R. 5162) (H.R. 5175) (H.R. 5177) (H.R. 5203) (H.R. 5205) (H.R. 5233) (H.R. 5234) (H.R. 5294) (H.R. 5313) (H.R. 5339) (H.R. 5438):

HOUSE REPORT No. 99-1005 (Comm. of Conference).
SENATE REPORT No. 99-500 (Comm. on Appropriations).
CONGRESSIONAL RECORD, Vol. 132 (1986):

Sept. 25, considered and passed House.

Sept. 29, considered and passed Senate, amended.

Oct. 15, House agreed to conference report, receded and concurred in certain Senate amendments, in others with amendments.

Oct. 16, Senate agreed to conference report, concurred in certain House amendment and receded from another.

Oct. 17, Senate concurred in certain House amendments with an amendment; House receded from certain Senate amendments and concurred in another.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 22 (1986):
 Oct. 30, Presidential statement.



Public Law 99-591
99th Congress

Joint Resolution

Making continuing appropriations for the fiscal year 1987, and for other purposes.

Oct. 30, 1986

[H.J. Res. 738]

Resolved by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are hereby appropriated, out of any money in the Treasury not otherwise appropriated, and out of applicable corporate or other revenues, receipts, and funds, for the several departments, agencies, corporations, and other organizational units of the Government for the fiscal year 1987, and for other purposes, namely:

SEC. 101. (a) Such amounts as may be necessary for programs, projects or activities provided for in the Agriculture, Rural Development, and Related Agencies Appropriations Act, 1987, at a rate of operations and to the extent and in the manner provided as follows, to be effective as if it had been enacted into law as the regular appropriations Act:

AN ACT

Making appropriations for Agriculture, Rural Development, and Related Agencies programs for the fiscal year ending September 30, 1987, and for other purposes.

TITLE I—AGRICULTURAL PROGRAMS

PRODUCTION, PROCESSING AND MARKETING

OFFICE OF THE SECRETARY

For necessary expenses of the Office of the Secretary of Agriculture, including not to exceed \$75,000 for employment under 5 U.S.C. 3109, \$1,623,000: *Provided*, That not to exceed \$8,000 of this amount shall be available for official reception and representation expenses, not otherwise provided for, as determined by the Secretary.

OFFICE OF THE ASSISTANT SECRETARY FOR ADMINISTRATION

For necessary expenses of the Office of the Assistant Secretary for Administration to carry out the programs funded in this Act, \$455,000.

RENTAL PAYMENTS (USDA)

(INCLUDING TRANSFERS OF FUNDS)

For payment of space rental and related costs pursuant to Public Law 92-313 for programs and activities of the Department of Agriculture which are included in this Act, \$48,728,000: *Provided*, That in the event an agency within the Department of Agriculture should require modification of space needs, the Secretary of Agriculture may transfer a share of that agency's appropriation made available

tions of the House of Representatives and the Committee on Foreign Relations and the Committee on Appropriations of the Senate, in accordance with the regular notification procedures of those Committees, a detailed notification for each lease with respect to which the authority is exercised; and

“(B) may be exercised only during the fiscal year 1987 and only with respect to one country, unless the Congress hereafter provides otherwise.

The preceding sentence does not constitute authorization of appropriations for payments by the United States for leased articles.”.

SEC. 148. Notwithstanding any other provisions of title 23, the Secretary of Transportation shall carry out the following project:

I-75 corridor in Kenton County, Kentucky, to examine the feasibility of unmanned radar units for safety purposes.

SEC. 149. Notwithstanding any other provision of law or this joint resolution, assistance to Bolivia shall be provided in accordance with the provisions of the Anti-Drug Abuse Act of 1986, as passed by the Senate on September 30, 1986.

SEC. 150. (a) Section 445(b)(1) of the Social Security Act is amended by striking out “June 30, 1985,” and inserting in lieu thereof “June 30, 1987,”.

(b) Section 445(d) of such Act is amended by striking out “June 30, 1984,” and inserting in lieu thereof “June 30, 1987,” and by striking out “June 30, 1987” and inserting in lieu thereof “June 30, 1988”.

SEC. 151. (a) Notwithstanding any other provision of law, the Administrator of General Services is authorized during fiscal year 1987 to accept periodic reimbursement from the Senate and from the House of Representatives for the cost of any equipment purchased for the Senate or the House of Representatives, respectively, with funds from the General Supply Fund established under section 109 of the Federal Property and Administrative Services Act of 1949. The amount of each such periodic reimbursement shall be computed by amortizing the total cost of each item of equipment over the useful life of the equipment, as determined by the Administrator, in consultation with the Sergeant at Arms and Doorkeeper of the Senate or the Clerk of the House of Representatives, as appropriate.

(b) Subsection (a) applies to reimbursements to the General Supply Fund for any equipment purchased for the Senate or the House of Representatives before, on, or after the date of enactment of this section.

SEC. 152. Section 107D(c)(1)(E)(ii) of the Agricultural Act of 1949 (7 U.S.C. 1445b-3(c)(1)(E)(ii)) is amended by striking out “marketing year for such crop” and inserting in lieu thereof “first 5 months of the marketing year for the 1986 crop and the marketing year for each of the 1987 through 1990 crops”.

SEC. 153. (a) The Congress finds that the activities conducted under the authorities of the Foreign Assistance Act of 1961 have contributed greatly to the alleviation of human suffering and the promotion of economic development in the recipient countries. The Congress finds further that changing circumstances in the developing countries and changing availability of resources from the United States require that a comprehensive review of the activities under that Act be undertaken.

(b) It is, therefore, the sense of the Congress that the President should undertake a comprehensive review of the activities authorized by the Foreign Assistance Act of 1961 and should send to the Committees on Appropriations and to the Senate Foreign Rela-

main terminal at Washington Dulles International Airport, and

(B) with the National Capital Planning Commission before undertaking development that would alter the skyline of Washington National Airport when viewed from the opposing shoreline of the Potomac River or from the George Washington Parkway.

(e) OPERATION LIMITATIONS.—

(1) HIGH DENSITY RULE.—The Administrator may not increase the number of instrument flight rule takeoffs and landings authorized for air carriers by the High Density Rule (14 C.F.R. 93.121 et seq.) at Washington National Airport on the date of the enactment of this title and may not decrease the number of such takeoffs and landings except for reasons of safety.

(2) ANNUAL PASSENGER LIMITATIONS.—The Federal Aviation Administration air traffic regulation entitled "Modification of Allocation: Washington National Airport" (14 C.F.R. 93.124) shall cease to be in effect on the date of the enactment of this title.

SEC. 6010. AUTHORITY TO NEGOTIATE EXTENSION OF LEASE.

The Secretary and the Airports Authority may at any time negotiate an extension of the lease entered into under section 6005(a).

SEC. 6011. SEPARABILITY.

Except as provided in section 6007(h), if any provision of this title or the application thereof to any person or circumstance, is held invalid, the remainder of this title and the application of such provision to other persons or circumstances shall not be affected thereby.

SEC. 6012. NONSTOP FLIGHTS.

PERIMETER RULE.—An air carrier may not operate an aircraft nonstop in air transportation between Washington National Airport and another airport that is more than 1,250 statute miles away from Washington National Airport.

Approved October 30, 1986.

Note: When the President signed H.J. Res. 738 on October 18, 1986, it was assigned Public Law No. 99-500. The following statement was issued by the President in conjunction with his signing of Public Law 99-591:

On October 17, 1986, I was presented by the Congress with an enrolled resolution designated H.J. Res. 738, a joint resolution making continuing appropriations for the

fiscal year 1987, and for other purposes. I signed this measure into law on October 18, 1986. I have since learned that H.J. Res. 738 was not properly enrolled, in that a small number of paragraphs of text were omitted due to clerical error.

The provisions I signed into law on October 18 remain the law of the land. The Supreme Court has held that transmission errors of this sort do not in any way vitiate the legal effect of a President's signature. Accordingly, that which was signed became law.

H.J. Res. 738 has since been properly enrolled and has been presented to me for signature. My signing of H.J. Res. 738 today will enable the provisions previously omitted to become law as well.

LEGISLATIVE HISTORY—H.J. Res. 738 (H.R. 5052) (H.R. 5161) (H.R. 5162) (H.R. 5175) (H.R. 5177) (H.R. 5203) (H.R. 5205) (H.R. 5233) (H.R. 5234) (H.R. 5294) (H.R. 5313) (H.R. 5339) (H.R. 5438):

HOUSE REPORTS: No. 99-1005 (Comm. of Conference).

SENATE REPORTS: No. 99-500 (Comm. on Appropriations).

LEGISLATIVE HISTORY—H.J. Res. 738—Continued**CONGRESSIONAL RECORD, Vol. 132 (1986):**

Sept. 25, considered and passed House.

Sept. 29, 30, Oct. 1-3, considered and passed Senate, amended.

Oct. 15, House agreed to conference report, receded and concurred in certain Senate amendment, in others with amendments.

Oct. 16, Senate agreed to conference report, concurred in certain House amendment and receded from another.

Oct. 17, Senate concurred in certain House amendment with an amendment; House receded from certain Senate amendments and concurred in another.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 22 (1986):

Oct. 30, Presidential statement.



CONTINUING APPROPRIATIONS, 1987

SEPTEMBER 29 (legislative day, SEPTEMBER 24), 1986.—Ordered to be printed

Mr. HATFIELD, from the Committee on Appropriations,
submitted the following

REPORT

[To accompany H.J. Res. 738]

The Committee on Appropriations, to which was referred the joint resolution (H.J. Res. 738) making continuing appropriations for fiscal year 1987, and for other purposes, reports the same to the Senate with various amendments and presents herewith information relative to the recommended joint resolution.

INTRODUCTION

The Committee on Appropriations has reported all 13 regular appropriations bills to provide funding for the fiscal year beginning on October 1, 1986. The Senate has considered and passed six of these bills: the fiscal year 1987 Military Construction, Legislative Branch, Labor-HHS-Education, Interior, District of Columbia, and Transportation appropriations bills. Conference action has been completed on the Legislative Branch appropriations bill. The remaining seven regular appropriations bills have been reported by the Committee. These include the fiscal year 1987 Treasury-Postal Service, Commerce-Justice-State, Agriculture, Energy-Water Development, Defense, Foreign Assistance, and HUD-Independent Agencies appropriations bills. The House has passed all regular appropriations bills for fiscal year 1987, with the exception of the Defense and Foreign Assistance bills.

This continuing resolution provides full-year funding—through September 30, 1987—for all 13 regular appropriations bills. Upon enactment into law of any of these bills, the relevant provisions of this continuing resolution will cease to apply, and the regular bill will become the funding device.

No material re Social Security in this report.

MAKING CONTINUING APPROPRIATIONS FOR FISCAL YEAR 1987

CONFERENCE REPORT

TO ACCOMPANY

H.J. RES. 738



OCTOBER 15, 1986.—Ordered to be printed

MAKING CONTINUING APPROPRIATIONS FOR FISCAL YEAR 1987

OCTOBER 15, 1986.—Ordered to be printed

Mr. WHITTEN, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany H.J. Res. 738]

The Committee of Conference on the disagreeing votes of the two Houses on the amendments of the Senate to the bill (H.J. Res. 738) "making continuing appropriations for the fiscal year 1987, and for other purposes," having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its amendments numbered 61, 62, 63, 64, 65, 66, 67, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 95, 97, 98, 99, 100, 102, 103, 104, 105, 106, 107, 110, 111, 112, 115, 116, 121, 123, and 125.

That the House recede from its disagreement to the amendments of the Senate numbered 13, 17, 18, 20, 21, 22, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 48, 49, 50, 52, 55, 57, 58, 118, and 126, and agree to the same.

Amendment numbered 1:

That the House recede from its disagreement to the amendment of the Senate numbered 1, and agree to the same with an amendment, as follows:

In lieu of the matter stricken and inserted by said amendment, insert the following:

(a) Such amounts as may be necessary for programs, projects or activities provided for in the Agriculture, Rural Development, and Related Agencies Appropriations Act, 1987, at a rate of operations and to the extent and in the manner provided as follows, to be effective as if it had been enacted into law as the regular appropriations Act:

lar provision is included in the Department of Defense Appropriations Act, 1987, as set forth in amendment number 3.

MEDICARE REGIONAL REFERRAL CENTERS—WAIVERS

Amendment No. 73: Deletes language proposed by the Senate which would have modified section 1886 of the Social Security Act with respect to qualification of regional referral centers under the Medicare program. The House bill contained no similar provision.

The conferees have deleted Senate language relating to a specific group of hospitals making applications under section 1886(d)(5)(C)(i) of the Social Security Act. These hospitals, located in States whose waivers under section 1886(c) of the Social Security Act or section 402 of the Social Security Amendments of 1967 and terminated on September 30, 1985 or December 31, 1985, are unduly prejudiced by existing regulations from making applications for regional referral centers under the Medicare Prospective Payment System. The conferees believe these hospitals should have every right to a determination with respect to reclassification as regional referral centers. Therefore, the conferees direct the Secretary to immediately make determinations with respect to reclassification as regional referral centers based on available data for the period ending September 30, 1986 for the cost reporting period for fiscal year 1987.

AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) DEMONSTRATIONS

Amendment No. 74: Deletes language proposed by the Senate which would have directed the Secretary of the Department of Health and Human Services to approve a demonstration project for Fresno County, California to promote employment of wage earners in families receiving assistance under the AFDC cash assistance program. The House bill contained no similar provision.

The conferees have deleted Senate language directing the Secretary of Health and Human Services to approve a demonstration project in Fresno County, California. However, the conferees believe the project has merit as a testing ground for a new approach to the welfare problem and urge the Secretary to give Fresno County's application favorable consideration.

Amendment No. 75: Deletes a provision proposed by the Senate regarding certain pre-inspection activities. The INS portion of this amendment is addressed in Amendment No. 2.

Amendment No. 76: Deletes a provision proposed by the Senate regarding the Tax Reform Act.

AIRPORT DEVELOPMENT REIMBURSEMENTS

Amendment No. 77: Deletes language proposed by the Senate permitting airports to expend private funds for development and to receive later reimbursement under certain conditions.

Amendment No. 78: Deletes Senate language which would have amended the Public Safety Officers Death Benefits Act to include coverage for members of public rescue squads or ambulance crews who were responding to a fire, rescue or police emergency. The House bill contained no provision on this item. This matter is addressed in Amendment No. 2.

CONNECTICUT HOSPICE WAIVER

Amendment No. 97: Deletes language proposed by the Senate which would have granted a waiver of certain requirements of the Social Security Act for the Connecticut Hospice. The House bill contained no similar provision.

The conferees have deleted without prejudice Senate language which would have amended the Tax Equity and Fiscal Responsibility Act of 1982 to permanently waive the 80/20 home care to inpatient days ratio and impose a new 50/50 ratio for the Connecticut Hospice. This issue is currently being considered by the authorizing committees. Specifically, this provision is included in H.R. 1868, the Medicare Fraud and Abuse Bill, as reported to the Senate by the Finance Committee. It also is currently an issue in conference on H.R. 5300, the Reconciliation Bill.

The conferees agree that this facility is in a unique situation. It is the oldest hospice in the nation and was in existence before the hospice-related Medicare law was enacted. Moreover, it is the only hospice in the country to provide inpatient services for an entire State. The conferees urge the authorizing committees to carefully consider the exceptional status of this facility in the long term resolution of this issue.

Amendment No. 98: Deletes language proposed by the Senate proposing to return control of U.S. Forest Service lands to the Department of Energy. The proposed amendment has been incorporated into amendment number 5.

Amendment No. 99: Deletes Senate language amending the Food Security Act of 1985 to extend authorization for the non-profit national rural development and finance corporation for fiscal year 1987 and providing that \$20,000,000 in guaranteed loans for the national rural development and finance program remain available until expended. The same provision was agreed to and included as section 641 of amendment number 1.

Amendment No. 100: Deletes a Senate provision which would have expressed the sense of the Senate concerning unauthorized re-transmissions of U.S. TV programming signals in Canada. The House bill contained no provision on this matter.

WORK INCENTIVES DEMONSTRATIONS

Amendment No. 101: Inserts language proposed by the Senate with respect to Work Incentives (WIN) demonstration projects and changes section number. This amendment amends the Social Security Act to establish a State application deadline for WIN demonstration projects of June 30, 1987 and to extend the duration of all projects to June 30, 1988. Under current law the projects would cease on June 30, 1987. The House bill contained no similar provision.

Amendment No. 102: Deletes a Senate provision which would have amended 18 U.S.C. 2516(2) to permit wiretapping by state law enforcement officials in certain hostage taking situations. The House bill contained no provision on this matter.

Amendment No. 103: Deletes language proposed by the Senate that disapproves uranium enrichment criteria. Action on this amendment has been incorporated into amendment number 5.

Amendment No. 104: Delete language proposed by the Senate extending the period for the commencement of construction under the housing development program. That language has been included in the conference agreement on H.R. 5313, the 1987 HUD-Independent Agencies Appropriations Act.

Amendment No. 105: Deletes a Senate provision which would have amended chapter 11 of title 11 of the Bankruptcy Code to require that retired former employees under a medical or hospital insurance plan established by a debtor prior to filing a bankruptcy petition shall be paid benefits under such plan until May 15, 1987. The provision would have established certain other requirements and would have provided that this section shall not apply during any period in which a case is subject to chapter 7 of the Bankruptcy Code. The House bill contained no provision on this item. This matter is included in Amendment No. 2.

MEDICAID WAIVER—MEDICAL UNIVERSITY OF SOUTH CAROLINA

Amendment No. 106: Deletes language proposed by the Senate which would have amended title XIX of the Social Security Act to require payment of a disputed Medicaid claim related to the Medical University of South Carolina. The House bill contained no similar provision.

While the conference has not adopted statutory language proposed by the Senate, the conferees direct the Administrator of the Health Care Financing Administration to carefully review the University's appeal of this matter in light of the unique nature of this claim. This dispute relates solely to a nine month period of FY 1985 during which all parties appear to have acted in good faith. The conferees believe that this fact should be taken into consideration when the Administrator makes his final decision.

Amendment No. 107: Deletes a Senate provision which would have required all telephones sold, rented or distributed by any other means in the U.S. after July 1, 1987 to be hearing-aid compatible as defined in FCC regulations. The language provided that this requirement would not apply to any telephone manufactured before July 1, 1987 or which is not required to be registered under 47 C.F.R. 68. The House bill contained no provision on this matter.

CONGRESSIONAL OFFICE EQUIPMENT

Amendment No. 108: Inserts language proposed by the Senate regarding reimbursement by the Senate to the General Supply Fund for the cost of equipment (including furniture, furnishings, and office equipment) purchased for the Senate, amended to include provision for the House of Representatives, and to change a section number.

Amendment No. 109: Includes Senate language amending the Agricultural Act of 1949 regarding the basis for computation of emergency compensation under the 1986 crop wheat program. No similar provision was contained in the House bill.

Deletes Senate language amending the Conservation Reserve program to allow alfalfa and other multi-year grasses and legumes in rotation, as approved by the Secretary, to be considered agricul-



Finder's Aid
P.L. 99-509, (100 Stat. 1971) Approved October 21, 1986
Omnibus Budget Reconciliation Act of 1986

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
Evidence and Procedure --Treatment of Service Under State and Local Agreements (conforming amendment)	205(c)(1)(D)(i)	9002(c)(2) (A)	1971	528	----	----
Evidence and Procedure --Treatment of Service Under State and Local Agreements (conforming amendment)	205(c)(5)(F)(iii)	9002(c)(2) (B)(i)	1971	528	----	----
Evidence and Procedure --Treatment of Service Under State and Local Agreement (conforming amendment)	205(c)(5)(F)(iii)	9002(c)(2) (B)(ii)	1971	528	----	----
Computations--Cost-of- Living Increase-- Elimination of 3- Percent Trigger	215(i)(1)(B)	9001(a)	1969	421, 415, 422, 528	----	267
Computations--Cost-of- Living Increase-- Elimination of 3- Percent Trigger (conforming amendment)	215(i)(2)(C)(i)	9001(b)(1) (A)(i)	1970	529	----	----
Computation--Cost-of- Living Increase-- Elimination of 3- Percent Trigger (conforming amendment)	215(i)(2)(C)(ii)	9001(b)(1) (A)(ii)	1970	529	----	----

Note: There is no material relating to amendments to the Social Security Act contained in House Report No. 99-479 which is shown in the "Legislative History" appearing at the end of P.L. 99-509.

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
Computations--Cost-of-Living Increase-- Elimination of 3- Percent Trigger (technical amendment)	215(i)(2)(C)(ii) Redesignated as (i)	9001(b)(1) (A)(i)	1970	529	----	----
Computations--Cost-of-Living Increase-- Elimination of 3- Percent Trigger (technical amendment)	215(i)(2)(C)(iii) Redesignated as (ii)	9001(b)(1) (A)(i)	1970	529	----	----
Computations--Cost-of-Living Increase-- Elimination of 3- Percent Trigger (conforming amendment)	215(i)(4)	9001(b)(1) (B)	1970	529	----	----
Computations--Cost-of-Living Increase-- Elimination of 3- Percent Trigger (conforming amendment)	215(i)(5)(A)(i)	9001(b)(1) (C)	1970	530	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(d)(6)(A)	9002(c)(2) (C)(i)	1972	415, 421, 423, 531	----	367
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(d)(6)(F)	9002(c)(2) (C)(ii)	1972	531	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(d)(8)(D)	9002(c)(2) (D)	1972	532	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(e) Repealed	9002(c)(1)	1971	532	----	----

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(f) Redesignated as (e)	9002(c)(1)	1971	533	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(e)(1) as Redesignated	9002(c)(2) (E)	1972	533	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(g) Redesignated as (f)	9002(c)(1)	1971	533	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(h) Repealed	9002(c)(1)	1971	533	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(i) Repealed	9002(c)(1)	1971	534	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(j) Repealed	9002(c)(1)	1971	534	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(k) Redesignated as (g)	9002(c)(1)	1971	534	----	----

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(l) Redesignated as (h)	9002(c)(1)	1971	535	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(m) Redesignated as (i)	9002(c)(1)	1971	535	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(n) Redesignated as (j)	9002(c)(1)	1971	535	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(o) Redesignated as (k)	9002(c)(1)	1971	535	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(p) Redesignated as (l)	9002(c)(1)	1971	536	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(q) Repealed	9002(c)(1)	1971	536	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(r) Repealed	9002(c)(1)	1971	538	----	----

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(s) Repealed	9002(c)(1)	1971	539	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(t) Repealed	9002(c)(1)	1971	539	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(u) Redesignated as (m)	9002(c)(1)	1971	540	----	----
State and Local Agreements--Deposits of Social Security Contributions by Governmental Employers (conforming amendment)	218(w) Repealed	9002(c)(1)	1971	----	----	----
Reduction of Benefits Based on Disability-- Deposits of Social Security Contributions by State and Local Governmental Employers (conforming amendments)	224(a)(2)(B)	9002(c)(2) (F)	1972	540	----	----
Child Support-- Statutory Procedures Prohibiting Retro- active Modifications	466(a)(9) New	9103(a)	1973	----	155	272
Foster Care and Adoption Assistance-- Collection of Data	479 New	9443	2073	128	----	418
Maternal and Child Health Services-- Authorization of Appropriations	501(a)	9441(a)	2071	126, 173	----	416

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
Maternal and Child Health Services-- Allotments to States-- Additional Appropriations	502(a)(1)	9441(b)(1)	2071	----	----	416
Maternal and Child Health Services-- Allotments to States-- Additional Appropriations	502(b)	9441(b)(2) (A)	2071	----	----	416
Maternal and Child Health Services-- Allotments to States-- Additional Appropriations	502(b)(3)	9441(b)(2) (B)	2071	----	----	416
Maternal and Child Health Services-- Allotments to States-- Additional Appropriations	502(c) New	9441(b)(3)	2071	----	----	416
Maternal and Child Health Services-- Allotments to States-- Additional Appropriations	502(d) New	9441(b)(3)	2072	----	----	416
General Provisions-- Exclusions Resulting from Conviction of Certain Medicare Offenses--Clarification	1128(f) New	9317(c)	2008	73, 133	----	316
General Provisions-- Civil Monetary Penalties--Payment to Induce Limited Physician Services (conforming amendment)	1128A	9313(c)(1) (A)	2003	----	----	----
General Provisions-- Civil Monetary Penalties--Payment to Induce Limited Physician Services (conforming amendment)	1128A(a)(1)	9313(c)(1) (B)	2003	----	----	----

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
General Provisions-- Civil Monetary Penalties--Payment to Induce Limited Physician Services (conforming amendment)	1128A(b) Redesignated as (c)	9313(c)(1) (D)	2003	---	---	---
General Provisions-- Civil Monetary Penalties and Exclusions--Payment to Induce Limited Physician Services	1128A(b) New	9313(c)(1) (E)	2003	73, 444	---	316
General Provisions-- Civil Monetary Penalties and Exclusions--Collateral Estoppel Effect of Criminal Conviction	1128A(c)(3) New	9317(a)	2008	73	---	316
General Provisions-- Civil Monetary Penalties and Exclusions--Hearing Officer Authority to Sanction Misconduct	1128A(c)(4) New	9317(b)	2008	73	---	316
General Provisions-- Civil Monetary Penalties--Payment to Induce Limited Physicians Services (technical amendment)	1128A(c) Redesignated as (d)	9313(c)(1) (D)	2003	---	---	---
General Provisions-- Civil Monetary Penalties--Payment to Induce Limited Physicians Services (technical amendment)	1128A(d) Redesignated as (e)	9313(c)(1) (D)	2003	---	---	---
General Provisions-- Civil Monetary Provisions--Payment to Induce Limited Physicians Services (technical amendment)	1128A(e) Redesignated as (f)	9313(c)(1) (D)	2003	---	---	---

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
General Provisions-- Civil Monetary Provisions--Payment to Induce Limited Physicians Services (technical amendment)	1128A(f) Redesignated as (g)	9313(c)(1) (D)	2003	----	----	----
General Provisions-- Civil Monetary Provisions--Payment to Induce Limited Physicians Services (technical amendment)	1128A(f)	9313(c)(1) (C)	2003	----	----	----
General Provisions-- Civil Monetary Provisions--Payment to Induce Limited Physicians Services (technical amendment)	1128A(g) Redesignated as (h)	9313(c)(1) (D)	2003	----	----	----
General Provisions-- Civil Monetary Provisions--Payment to Induce Limited Physicians Services (technical amendment)	1128A(h) Redesignated as (i)	9313(c)(1) (D)	2003	----	----	----
General Provisions-- Development of Prospective Payment Methodology--Outpatient Hospital Services-- Ambulatory Surgical Procedures	1135(d) New	9343(f)	2041	----	----	352, 355
General Provisions-- Income and Eligibility Verification Systems-- States Not Required to Verify Eligibility of All Recipients	1137(a)(4)(C)	9101	1972	416, 424, 543	----	271
General Provisions-- Organ Procurement-- Hospital Protocol and Agency Standards	1138 New	9318(a)	2009	79, 134	----	318

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
Health Care Peer Review—Peer Review Board Consumer Representative (technical amendment)	1152(1)	9353(b)(1) (A)	2046	----	----	----
Health Care Peer Review—Peer Review Board—Consumer Representative (technical amendment)	1152(2)	9353(b)(1) (B)	2046	----	----	----
Health Care Peer Review—Peer Review Board—Consumer Representative	1152(3) New	9353(b)(1) (C)	2046	417, 457, 459	----	356, 358, 361
Health Care Peer Review—Timely Furnishing of Hospital Information by Intermediaries for Peer Review	1153(g) New	9352(a)(1)	2044	417, 458, 459	----	358, 360, 361
Health Care Peer Review—Ambulatory Surgical Procedures— Peer Review (conforming amendment)	1154(a)(1)	9343(d)(1)	2040	----	----	353, 355
Health Care Peer Review—Quality of Care Review—Allocation of Activities Among Different Cases and Settings	1154(a)(4)	9353(a)(1)	2045	417, 457, 458	----	357, 359, 360
Health Care Peer Review—Health Maintenance Organizations and Competitive Medical Plans (technical amendment)	1154(a)(4) Redesignated as (4)(A)	9353(a)(2) (A)	2045	----	----	----
Health Care Peer Review—Health Maintenance Organizations and Competitive Medical Plans	1154(a)(4)(B) New	9353(a)(2) (B)	2045	457, 459	----	358, 360

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
Health Care Peer Review--Health Maintenance Organizations and Competitive Medical Plans--Level of Effect (Enrolled vs. Non- Enrollees)	1154(a)(4)(B)	9353(a)(2) (C)	2045	457, 459	---	360
Health Care Peer Review--Health Maintenance Organizations and Competitive Medical Plans--Quality of Care--Secretarial Procurement Contracts	1154(a)(4)(C) New	9353(a)(2) (D)	2045	---	---	360
Health Care Peer Review--Review of Early Readmission Cases	1154(a)(13) New	9352(b)	2044	417, 457, 458	146	357, 359, 360
Health Care Peer Review--Quality of Care--Review of Complaints	1154(a)(14) New	9353(c)(1)	2047	457, 459	147	356, 360, 361
Health Care Peer Review--Ambulatory Surgical Procedures-- Peer Review	1154(d) New	9343(d)(2)	2040	---	147	353, 355
Health Care Peer Review--Review of Hospital Determination that Inpatient Care Not Required	1154(e) New	9351(a)	2043	457, 458	146	356, 357, 359, 360
Health Care Peer Review--Methods of Identifying Types of Services Likely to be Substandard	1154(f) New	9353(a)(3)	2046	457, 458	147	356, 357, 359, 360
Health Care Peer Review--Quality of Care--Sharing Information by Peer Review Organizations	1160(b)(1)(C)	9353(d)(1)	2047	417, 458, 459	147	356, 360, 361

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
Medicare--Changes in Hospital Deductible	1813(b)	9301(a)	1981	416, 426	144	273
Medicare--Payment to Providers--Periodic Interim Payments	1815(e) New	9311(a)(1)	1996	417, 439	143	296
Medicare--Use of Public Agency or Private Organizations to Facilitate Payment-- Definition of "Fiscal Intermediary"	1816(a)	9352(a)(2)	2044	----	----	----
Medicare--Use of Public Agency or Private Organizations to Facilitate Payment-- Prompt Payment (technical amendment)	1816(c) Redesignated as (c)(1)	9311(b)(1)	1977	482	----	----
Medicare--Use of Public Agency or Private Organizations to Facilitate Payment-- Prompt Payment	1816(c)(2) New	9311(b)(2)	1977	97, 436, 482	143	297
Medicare--Scope of Benefits--Payment for Services of a Certified Registered Nurse Anesthetist (technical amendment)	1832(a)(2)(B)(i)	9320(d)(1)	2013	----	----	----
Medicare--Scope of Benefits--Payment for Services of a Certified Registered Nurse Anesthetist (technical amendment)	1832(a)(2)(B)(ii)	9320(d)(2)	2014	----	----	----
Medicare--Scope of Benefits--Payment for Services of a Certified Registered Nurse Anesthetist	1832(a)(2)(B)(iii) New	9320(d)(3)	2014	83, 437	----	321

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Medicare--Scope of Benefits--Outpatient Occupational Therapy Services	1832(a)(2)(C)	9337(a)	2033	81, 135	148	344
Medicare--Scope of Benefits--Ambulatory Surgery--Coinsurance and Deductible	1832(a)(2)(F)(i)	9343(e)(1)	2041	---	142	353, 355
Medicare--Scope of Benefits--Ambulatory Surgery--Coinsurance and Deductible	1832(a)(2)(F)(ii)	9343(e)(1)	2041	---	142	353, 355
Medicare--Payment of Benefits--Amount of Payment--Certified Registered Anesthetist (technical amendment)	1833(a)(1)(E)	9320(e)(1)	2014	---	---	---
Medicare--Payment of Benefits--Amount of Payment--Certified Registered Anesthetist (technical amendment)	1833(a)(1)(G)	9320(e)(1)	2014	136	---	---
Medicare--Payment of Benefits--Amount of Payment--Certified Registered Anesthetist	1833(a)(1)(H) New	9320(e)(1)	2014	83, 136	---	321
Medicare--Payment of Benefits--Amount for Ambulatory Surgery	1833(a)(4)	9343(a)(1) (A)	2039	---	142	352
Medicare--Payment of Benefits--Ambulatory Surgery--Coinsurance and Deductible	1833(b)(3) Stricken	9343(e)(2) (A)	2041	---	142	353, 355
Medicare--Payment of Benefits--Ambulatory Surgery--Coinsurance and Deductible (technical amendment)	1833(b)(4) Redesignated as (3)	9343(e)(2) (A)	2041	---	---	---

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
Medicare--Payment of Benefits--Ambulatory Surgery--Coinsurance and Deductible (technical amendment)	1833(b)(5) Redesignated as (4)	9343(e)(2) (A)	2041	----	----	----
Medicare--Payment of Benefits--Outpatient Occupational Therapy Services--Limitation on Payments (technical amendment)	1833(g)	9337(b)(1)	2033	137	----	----
Medicare--Payment of Benefits--Outpatient Occupational Therapy Services--Limitation on Payments	1833(g)	9337(b)(2)	2033	81, 137	148	344
Medicare--Payment of Benefits--Clinical Diagnostic Laboratory Tests--Fee Schedule-- Qualified Hospital Laboratory for Outpatients	1833(h)(1)(B)	9339(a)(1) (A)	2036	91	----	346
Medicare--Payment of Benefits--Clinical Diagnostic Laboratory Tests--National Fee Schedule--2-Year Delay	1833(h)(1)(B)	9339(b)(1)	2036	91	----	347
Medicare--Payment of Benefits--Clinical Diagnostic Laboratory Tests--Fee Schedule-- Qualified Hospital Laboratory	1833(h)(1)(C)	9339(a)(1) (B)(i)	2036	91	----	346
Medicare--Payment of Benefits--Clinical Diagnostic Laboratory Tests--Fee Schedule-- Qualified Hospital Laboratory Hospital	1833(h)(1)(C)	9339(a)(1) (B)(ii)	2036	91	----	346

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
Medicare--Payment of Benefits--Clinical Diagnostic Laboratory Tests--Fee Schedule-- Definition of "Qualified Hospital Laboratory"	1833(h)(1)(D) New	9339(a)(1) (C)	2036	91	----	346
Medicare--Payment of Benefits--Clinical Diagnostic Laboratory Tests--Fee Schedule-- Qualified Hospital Laboratory	1833(h)(2)	9339(a)(1) (D)	2036	91	----	346
Medicare--Payment of Benefits--Clinical Diagnostic Laboratory Tests--National Fee Schedule--2-Year Delay (conforming amendment)	1833(h)(2)	9339(b)(2)	2036	91	----	----
Medicare--Payment of Benefits--Clinical Diagnostic Laboratory Tests--Time and Travel Expenses--Collection of Samples (technical amendment)	1833(h)(3) Redesignated as (3)(A)	9339(c)(1) (A)	2036	138	----	----
Medicare--Payment of Benefits--Clinical Diagnostic Laboratory Tests--Time and Travel Expenses	1833(h)(3)(B) New	9339(c)(1) (B)	2036	91, 138	----	347
Medicare--Payment of Benefits--Ambulatory Surgical Procedure List Update	1833(i)(1)	9343(b)(2)	2040	----	143	352
Medicare--Payment of Benefits--Ambulatory Surgical Procedure-- Annual Review of Rates	1833(i)(2)(A)	9343(b)(1)	2040	----	143	352
Medicare--Payment of Benefits--Ambulatory Surgical Procedure-- Coinsurance	1833(i)(2)(A)	9343(e)(2) (B)	2041	----	143	352

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Medicare--Payment of Benefits--Ambulatory Surgical Procedure in Physicians Office-- Coinsurance	1833(i)(2)(B)	9343(e)(2) (B)	2041	----	----	352
Medicare--Payment of Benefits--Surgical Procedure in Physicians Office--Annual Review of Rates	1833(i)(2)(B)	9343(b)(1)	2040	----	----	352
Medicare--Payment of Benefits--Outpatient Hospital Facilities Service--Ambulatory Surgical Procedures Amounts (technical amendment)	1833(i)(3) Redesignated as (4)	9343(a)(1) (B)	2039	----	----	----
Medicare--Payment of Benefits--Outpatient Hospital Facilities Service--Ambulatory Surgical Procedures Amounts	1833(i)(3) New	9343(a)(1) (B)	2039	----	143	352
Medicare--Payment of Benefits--Outpatient Hospital Facilities Services--Ambulatory Surgical Procedures Amounts (technical amendment)	1833(i)(4) Redesignated as (5)	9343(a)(1) (B)	2039	----	----	----
Medicare--Payment of Benefits--Service of a Certified Registered Nurse Anesthetist-- Establishment of a Fee Schedule	1833(l) New	9320(e)(2)	2014	83	----	321
Medicare--Payment of Claims of Providers-- Certification Standard-- Outpatient Occupational Therapy Services	1835(a)	9337(c)(2) (A)	2034	81, 142	148	344

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Medicare--Payment of Claims of Providers-- Certification Standard-- Outpatient Occupational Therapy Services	1835(a)	9337(c)(2) (B)	2034	81, 142	148	344
Medicare--Payment of Claims of Providers-- Certification Standard-- Outpatient Occupational Therapy Services	1835(a)(2)(C)	9337(c)(1) (A)	2034	81, 142	148	344
Medicare--Payment of Claims of Providers-- Certification Standard-- Outpatient Occupational Therapy Services	1835(a)(2)(C)(i)	9337(c)(1) (B)	2034	81, 142	148	344
Medicare--Payment of Claims of Providers-- Certification Standard-- Outpatient Occupational Therapy Services	1835(a)(2)(C)(ii)	9337(c)(1) (C)	2034	81, 142	148	344
Medicare--Enrollment-- Medicare as Secondary Payer--Special Enrollment Period for Employees Under Age 65	1837(i)(1)	9319(c)(1)	2011	----	139	320
Medicare--Enrollment-- Medicare as Secondary Payer--Special Enrollment Period for Employees Under Age 65	1837(i)(2)	9319(c)(2)	2011	----	139	320
Medicare--Enrollment-- Medicare as Secondary Payer--Special Enrollment Period for Employees Under Age 65 (technical amendment)	1837(i)(3) Redesignated as (3)(A)	9319(c)(3) (A)	2011	----	----	----
Medicare--Enrollment-- Medicare as Secondary Payer--Special Enrollment Period for Employees Under Age 65 (conforming amendment)	1837(i)(3)	9319(c)(3) (B)	2011	----	----	----

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Medicare--Enrollment-- Medicare as Secondary Payer--Special Enrollment Period for Employees Under Age 65	1837(i)(3)(B) New	9319(c)(3) (C)	2011	----	----	320
Medicare--Coverage Period--Effective Date of Voluntary Disenrollment	1838(b)	9344(b)(1)	2042	419, 456, 483	----	342
Medicare--Amounts of Premiums--Medicare as Secondary Payer-- Special Enrollment Period for Employees Under Age 65	1839(b)	9319(c)(4)	2012	----	----	320
Medicare--Amount of Premiums (technical correction)	1839(f)(2)(A)	9001(c)	1970	543	----	----
Medicare--Use of Carriers--Physicians Payment--Changing Medicare Appeal Rights-- Amounts in Controversy	1842(b)(3)(C)	9341(a)(2)	2038	95, 143	----	350
Medicare--Use of Carriers--Physicians Payment--Provision of Actual Charge Information to Nonparticipating Physicians (technical amendment)	1842(b)(3)(E)	9331(b)(2) (A)	2020	485	----	----
Medicare--Use of Carriers--Physicians Payment--Provision of Actual Charge Information to Nonparticipating Physicians (technical amendment)	1842(b)(3)(F)	9331(b)(2) (B)	2020	485	----	----

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Medicare--Use of Carriers--Physicians Payment--Programs for Recruitment and Retention of Participating Physicians (technical amendment)	1842(b)(3)(F)	9332(a)(1) (A)	2022	---	---	---
Medicare--Use of Carriers--Physicians Payment--Provision of Actual Charge Information to Nonparticipating Physicians	1842(b)(3)(G) New	9331(b)(2) (C)	2020	447, 449, 485	---	326, 328, 330
Medicare--Use of Carriers--Physicians Payment--Programs for Recruitment and Retention of Participating Physicians (technical amendment)	1842(b)(3)(G)	9332(a)(1) (B)	2022	485	---	---
Medicare--Use of Carriers--Physicians Payment--Programs for Recruitment and Retention of Participating Physicians	1842(b)(3)(H) New	9332(a)(1) (C)	2022	418, 448, 451, 485	---	327, 331
Medicare--Use of Carriers--Contracts-- Annualization of the Medicare Economic Index	1842(b)(3)	9331(c)(3) (A)	2021	418, 447, 448	141	325, 328, 331
Medicare--Use of Carriers--Physicians Payment--Determination of Maximum Allowable Prevailing Charges-- Participating Physicians	1842(b)(4)(A)(iii)	9331(a)(1)	2018	418, 447, 448, 486	140	325, 329
Medicare--Use of Carriers--Physicians Payment--Determination of Maximum Allowable Prevailing Charges-- Nonparticipating Physicians	1842(b)(4)(A)(iv) New	9331(a)(1)	2018	418, 447, 448, 486	140	325, 329

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Medicare--Use of Carriers--Physicians Payment--Determination of Maximum Allowable Prevailing Charges-- Participating and Nonparticipating Physicians	1842(b)(4)(A)(v) New	9331(a)(1)	2018	418, 447, 448, 486	140	325 329
Medicare--Use of Carriers--Physicians Payment--Expiration of the Extension of Certain Prevailing Charge Provisions (technical amendment)	1842(b)(4)(C)(i)	9331(a)(2) (A)	2018	486	----	----
Medicare--Use of Carriers--Physicians Payment--Expiration of the Extension of Certain Prevailing Charge Provisions	1842(b)(4)(C)(ii) Stricken	9331(a)(2) (B)	2018	447, 449, 486	141	----
Medicare--Use of Carriers--Physicians Payment--Limit on Actual Charges for Nonparticipating Physicians (conforming amendment)	1842(b)(4)(D)(iv) New	9331(b)(3)	2020	145, 487	----	----
Medicare--Use of Carriers--Physicians Payment--Furnishing of Services--Definitions of "Participating" and "Nonparticipating" Physicians	1842(b)(4)(E) New	9331(a)(3)	2018	148, 447, 487	----	----
Medicare--Use of Carriers--Physicians Payment--Services of Physician Assistant-- Payment to Employer (technical amendment)	1842(b)(6)(A)(i)	9338(c)(1)	2035	82, 145	----	----
Medicare--Use of Carriers--Physicians Payment--Services of Physician Assistant-- Payment to Employer (technical amendment)	1842(b)(6)(B)	9338(c)(2)	2035	82, 146	----	----
Medicare--Use of Carriers--Physicians Payment--Services of Physician Assistant-- Payment to Employer	1842(b)(6)(C) New	9338(c)(3)	2035	82, 146	----	345

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Medicare--Use of Carriers--Physicians Payment--Criteria Permitting Increases or Decreases in Reasonable Charge Limits (technical amendment)	1842(b)(8)(A)	9333(a)(2)	2025	146	----	----
Medicare--Use of Carriers--Physicians Payment--Criteria Permitting Increases or Decreases in Reasonable Charge Limits (technical amendment)	1842(b)(8)(A) Redesignated as (8)(A)(i)	9333(a)(1)	2025	146	----	----
Medicare--Use of Carriers--Physicians Payment--Criteria Permitting Increases or Decreases in Reasonable Charge Limits (technical amendment)	1842(b)(8)(B) Redesignated as (8)(A)(ii)	9333(a)(1)	2025	146	----	----
Medicare--Use of Carriers--Physicians Payment--Criteria Permitting Increases or Decreases in Reasonable Charge Limits	1842(b)(8)(B) New	9333(a)(3)	2025	85, 146, 419, 447, 449	140	332
Medicare--Use of Carriers--Physicians Payment--Consideration of Impact of Adjustment in Rates	1842(b)(8)(C) New	9333(a)(3)	2025	85, 447, 449	141	332
Medicare--Use of Carriers--Physicians Payment--Inherent Reasonableness Procedure--Publication of Notice of Change	1842(b)(9) New	9333(b)	2026	87, 447, 449	141	332

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Medicare--Use of Carriers--Physicians Payment--Reduction of Reasonable Charge Amount--Effect on Nonparticipating Physicians	1842(b)(10) New	9333(b)	2026	85, 447, 449	---	332
Medicare--Use of Carriers--Physicians Payment--Inherent Reasonableness Procedure (technical amendment)	1842(b)(9) Redesignated as (11)	9333(b)	2026	---	---	---
Medicare--Use of Carriers--Physicians Payment--Cataract Surgery--Reduction in Prevailing Reasonable Charge (technical amendment)	1842(b)(11)(A) as Redesignated	9334(a)(2)	2028	---	---	---
Medicare--Use of Carriers--Physicians Payment--Cataract Surgery--Reduction in Prevailing Reasonable Charge (technical amendment)	1842(b)(11)(A) Redesignated as (A)(i)	9334(a)(1)	2028	---	---	---
Medicare--Use of Carriers--Physicians Payment--Cataract Surgery--Reduction in Prevailing Reasonable Charge (technical amendment)	1842(b)(11)(B) Redesignated as (A)(ii)	9334(a)(1)	2028	---	---	---
Medicare--Use of Carriers--Physicians Payment--Cataract Surgery--Reduction in Prevailing Reasonable Charge	1842(b)(11)(B) New	9334(a)(3)	2028	88, 148, 450	---	332, 333, 336

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Medicare—Use of Carriers—Physicians Payment—Cataract Surgery—Reduction in Prevailing Reasonable Charge—Effect on Nonparticipating Physicians	1842(b)(11)(C) New	9334(a)(3)	2028	88, 148, 450	—	332, 333, 336
Medicare—Use of Carriers—Physicians Payment—Services of a Physician Assistant— Determination of Amount	1842(b)(12) New	9338(b)	2035	82,	—	345
Medicare—Use of Carriers—Physicians Payment—Prompt Payment of Claims Under Part B (technical amendment)	1842(c) Redesignated as (c)(1)	9311(c)(1)	1998	487	—	—
Medicare—Use of Carriers—Physicians Payment—Prompt Payment of Claims Under Part B	1842(c)(2) New	9311(c)(2)	1998	97, 488	—	297, 298, 300
Medicare—Use of Carriers—Incentives for Participation— Distribution of Directories of Participating Physicians	1842(h)(2)	9332(b)(1) (A)	2023	418, 448, 451	—	327, 331
Medicare—Use of Carriers—Incentives for Participation— Organization of Directories	1842(h)(4)	9332(b)(2)	2023	418, 448, 451, 489	—	327, 331
Medicare—Use of Carriers—Incentives for Participation— Notice to Beneficiaries of Directory Availability	1842(h)(5)	9332(b)(1) (B)(i)	2023	418, 448, 451, 489	—	331

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Medicare--Use of Carriers--Incentives for Participation-- Notice to Beneficiaries of Directory Availability	1842(h)(5)	9332(b)(1) (B)(ii)	2023	418, 448, 451, 489	---	331
Medicare--Use of Carriers--Incentives for Participation-- Distribution of Directories to Hospitals	1842(h)(6)	9332(b)(1) (C)(i)	2023	418, 448, 451, 489	---	327, 331
Medicare--Use of Carriers--Incentives for Participation-- Distribution Free of Charge to Hospitals	1842(h)(6)	9332(b)(1) (C)(ii)	2023	418, 448, 451, 489	---	327
Medicare--Use of Carriers--Physician Payment--General Limit on Actual Charge of Nonparticipating Physicians (technical amendment)	1842(j)(1) Redesignated as (1)(A)	9331(b)(1) (A)	2019	149, 489	---	---
Medicare--Use of Carriers--Physician Payment--General Limit on Actual Charge of Nonparticipating Physicians	1842(j)(1)(B) New	9331(b)(1) (B)	2019	85, 149, 418, 447, 448, 489	--- ---	326, 330
Medicare--Use of Carriers--Physician Payment--Determination of Charges for Particular Physicians' Services	1842(j)(1)(C) New	9331(b)(1) (B)	2019	450, 489	---	326, 330
Medicare--Use of Carriers--Prohibition of Submitting Bills for Which Payment May Not Be Made--Certified Registered Nurse Anesthetist (conforming amendment)	1842(j)(2)	9320(e)(3)	2015	---	---	---

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Medicare--Use of Carriers--Prohibition Against Billing for Unnecessary Treatment	1842(<u>l</u>) New	9332(c)(1)	2023	73, 448, 452, 490	---	327, 329, 332
Medicare--Use of Carriers--Disclosure of Information in Unassigned Claims by the Physician to Certain Elective Surgery Patients	1842(m) New	9332(d)(1)	2024	448, 452, 491	---	328, 329, 332
Medicare--Physician Payment Review Commission-- Additional Members	1845(a)(2)	9344(a)(1)	2042	94, 150, 419, 456, 492	---	342, 343
Medicare--Physician Payment Review Commission-- Recommendation by the Secretary as to Applications of Relative Value Scale (conforming amendment)	1845(b)(3)	9331(e)(2)	2022	----	----	----
Medicare--Physician Payment Review Commission--Extension of Deadline for Report	1845(e)(3)	9331(e)(3) (A)	2022	----	----	325, 329, 332
Medicare--Physician Payment Review Commission--Extension of Deadline for Development of Relative Value Scale by Secretary	1845(e)(3)	9331(e)(3) (B)	2022	----	141	325, 329, 332
Medicare--Physician Payment Review Commission-- Recommendation by the Secretary as to Applications of Relative Value Scale	1845(e)(4) New	9331(e)(1)	2021	----	141	325, 329, 332

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Medicare--Inpatient Hospital Services-- Services of Certified Registered Nurse Anesthetist Excluded	1861(b)(4)	9320(f)	2015	83, 151	----	321
Medicare--Definition of "Hospital"-- Requirement of Discharge Planning Process (technical amendment)	1861(e)(6) Redesignated as (6)(A)	9305(c)(1) (A)	1989	492	----	----
Medicare--Definition of "Hospital"-- Requirement of Discharge Planning Process	1861(e)(6)(B) New	9305(c)(1) (B)	1989	417, 431, 433, 492	145	285, 287, 291, 292
Medicare--Outpatient Occupational Therapy Services	1861(g) New	9337(d)(1)	2034	81, 151	148	344
Medicare--Definition of "Physician"-- Services an Optometrist Can Provide	1861(r)(4)	9336(a)	2033	81, 151	----	344
Medicare--Medical and Other Health Services-- Outpatient Occupational Health Services	1861(s)(2)(D)	9337(d)(2)	2034	81, 152	148	344
Medicare--Medical and Other Health Services-- Renal Services-- Immunosuppressive Drugs (technical amendment)	1861(s)(2)(H)(ii)	9335(c)(1) (A)	2030	152	----	----
Medicare--Medical and Other Health Services-- Renal Services-- Immunosuppressive Drugs (technical amendment)	1861(s)(2)(I)	9335(c)(1) (B)	2030	152	----	----
Medicare--Medical and Other Health Services-- Services of a Physician Assistant (technical amendment)	1861(s)(2)(I)	9338(a)(1)	2034	152	----	----

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Medicare--Medical and Other Health Services-- Renal Services-- Immunosuppressive Drugs	1861(s)(2)(J) New	9335(c)(1) (C)	2030	75, 152	---	337, 339, 341
Medicare--Medical and Other Health Services-- Services of a Physician Assistant (technical amendment)	1861(s)(2)(J)	9338(a)(2)	2034	152	---	---
Medicare--Medical and Other Health Services-- Services of a Physician Assistant	1861(s)(2)(K) New	9338(a)(3)	2034	82, 152	---	345
Medicare--Medical and Other Health Services-- Services of a Certified Registered Nurse Anesthetist (technical amendment)	1861(s)(9)	9320(b)(2)	2013	153	---	---
Medicare--Medical and Other Health Services-- Services of a Certified Registered Nurse Anesthetist (technical amendment)	1861(s)(10)	9320(b)(3)	2013	153	---	---
Medicare--Medical and Other Health Services-- Services of a Certified Registered Nurse Anesthetist (technical amendment)	1861(s)(11) Redesignated as (12)	9320(b)(1)	2013	153	---	---
Medicare--Medical and Other Health Services-- Services of a Certified Registered Nurse Anesthetist	1861(s)(11) New	9320(b)(4)	2013	83, 153	---	321
Medicare--Medical and Other Health Services-- Services of a Certified Registered Nurse Anesthetist (technical amendment)	1861(s)(12) Redesignated as (13)	9320(b)(1)	2013	153	---	---

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Medicare—Medical and Other Health Services— Services of a Certified Registered Nurse Anesthetist (technical amendment)	1861(s)(13) Redesignated as (14)	9320(b)(1)	2013	153	----	----
Medicare—Medical and Other Health Services— Services of a Certified Registered Nurse Anesthetist (technical amendment)	1861(s)(14) Redesignated as (15)	9320(b)(1)	2013	153	----	----
Medicare—Reasonable Cost—Limitations on Payment for Home Health Services (technical amendment)	1861(v)(1)(L) Redesignated as (L)(i)	9315(a)(1)	2005	----	----	----
Medicare—Reasonable Cost—Limitations on Payment for Home Health Services	1861(v)(1)(L)(i) as Redesignated	9315(a)(2)	2005	----	147	313
Medicare—Reasonable Cost—Limitations on Payment for Home Health Services	1861(v)(1)(L)(ii) New	9315(a)(2)	2005	78, 154	147	313
Medicare—Reasonable Cost—Exclusions of Provider Costs Incurred in Unsuccessful Appeal	1861(v)(1)(R) New	9313(a)(2)	2002	----	----	306, 308
Medicare—Reasonable Cost—Outpatient Occupational Therapy Services (conforming amendment)	1861(v)(5)(A)	9337(d)(3)	2034	81, 154	----	----
Medicare—Definition of "Services of a Certified Registered Nurse Anesthetist"	1861(bb) New	9320(c)	2013	83, 154	----	321
Medicare—Definition of "Discharge Planning Process"	1861(ee) New	9305(c)(2)	1989	431, 433, 492	145	287, 291

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Medicare--Exclusions from Coverage--Patient Outcome Assessment-- Research Unnecessary to Achieve Purpose (technical amendment)	1862(a)(1)(C)	9316(b)(1)	2007	155	----	----
Medicare--Exclusions from Coverage--Patient Outcome Assessment-- Research Unnecessary to Achieve Purpose (technical amendment)	1862(a)(1)(D)	9316(b)(2)	2007	155	----	----
Medicare--Exclusions from Coverage--Patient Outcome Assessment-- Research Unnecessary to Achieve Purpose	1862(a)(1)(E) New	9316(b)(3)	2007	71, 155	149	314
Medicare--Exclusions from Coverage-- Ambulatory Surgery-- Preventing Unbundling of Hospital Outpatient Services	1862(a)(14)	9343(c)(1)	2040	----	132	352
Medicare--Exclusions from Coverage--Non Exclusions of Services of a Certified Registered Nurse Anesthetist (conforming amendment)	1862(a)(14)	9320(h)(1)	2016	155	----	----
Medicare--Exclusions from Coverage-- Medicare as Secondary Payer for Disabled Employees of Large Employers	1862(b)(4) New	9319(a)	2010	----	139	320
Medicare--Exclusions from Coverage-- Medicare as Secondary Payer--Private Cause of Action	1862(b)(5) New	9319(b)	2011	----	140	320

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Medicare--Provider Compliance--Services of Certified Registered Nurse Anesthetist (technical amendment)	1864(a)	9320(h)(3)	2016	156	---	---
Medicare--Effect of Accreditation--Services of Certified Registered Nurse Anesthetist (technical amendment)	1865(a)	9320(h)(3) (A)	2016	156	---	---
Medicare--Effect of Accreditation--Discharge Planning Process	1865(a)	9305(c)(3) (A)	1990	431, 433, 494	145	285, 287, 291, 292
Medicare--Effect of Accreditation--Discharge Planning Process (conforming amendment)	1865(a)	9305(c)(3) (B)	1990	494,	---	---
Medicare--Agreements with Providers--Funding of Peer Review Organization Activities (technical amendment)	1866(a)(1)(F)(i) Redesignated as (I)	9353(e)(1) (A)(i)	2047	494	---	---
Medicare--Agreements with Providers--Funding of Peer Review Organization Activities (technical amendment)	1866(a)(1)(F)(ii) Redesignated as (II)	9353(e)(1) (A)(i)	2047	494	---	---
Medicare--Agreements with Providers--Funding of Peer Review Organization Activities (technical amendment)	1866(a)(1)(F)(iii) Redesignated as (III)	9353(e)(1) (A)(i)	2047	494	---	---
Medicare--Agreements with Providers--Funding of Peer Review Organization Activities (technical amendment)	1866(a)(1)(F) Redesignated as (F)(i)	9353(e)(1) (A)(ii)	2047	494	---	---
Medicare--Agreement with Providers Funding of Additional Peer Review Organization Activities	1866(a)(1)(F)(ii) New	9353(e)(1) (A)(iii)	2047	417, 458, 460, 495	---	356, 358, 360, 361

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Medicare--Agreement with Providers-- Services of Certified Registered Nurse Anesthetist (conforming amendment)	1866(a)(1)(H)	9320(h)(2)	2016	157	---	293
Medicare--Agreements with Providers-- Ambulatory Surgery-- Preventing of Unbundling of Outpatient Services (conforming amendment)	1866(a)(1)(H)	9343(c)(2) (A)	2040	---	---	---
Medicare--Agreements with Providers-- Ambulatory Surgery-- Preventing of Unbundling of Outpatient Services (conforming amendment)	1866(a)(1)(H)	9343(c)(2) (B)	2040	---	---	---
Medicare--Agreements with Providers--Notice by Hospitals of Patient Rights and Liabilities (technical amendment)	1866(a)(1)(K)	9305(b)(1) (A)	1989	---	---	---
Medicare--Agreements with Providers--Notice by Hospitals of Patient Rights and Liabilities (technical amendment)	1866(a)(1)(L)	9305(b)(1) (B)	1989	---	---	---
Medicare--Agreements with Providers-- Furnishing Information Re: Participating Physicians (technical amendment)	1866(a)(1)(L)	9332(e)(1) (A)	2025	---	---	---
Medicare--Agreements with Providers-- New Notice by Hospitals of Patient Rights and Liabilities	1866(a)(1)(M)	9305(b)(1) (C)	1989	416, 431, 433, 495	145	284, 286, 290, 292
Medicare--Agreements with Providers-- Furnishing Information Re: Participating Physicians (technical amendment)	1866(a)(1)(M)	9332(e)(1) (B)	2025	---	---	---

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Medicare--Agreements with Providers-- Furnishing Information Re: Participating Physicians	1866(a)(1)(N) New	9332(e)(1) (C)	2025	157, 418, 451, 488, 495	---	328, 322
Medicare--Agreements with Providers-- Funding of Additional Peer Review Organization Activities	1866(a)(4) New	9353(e)(1) (B)	2047	417, 458, 460, 496,	---	356, 358, 360, 361
Medicare--Agreements with Providers-- Definition of Provider- Outpatient Occupational Therapy (conforming amendment)	1866(e)	9337(c)(2) (A)	2034	158	---	---
Medicare--Agreements with Providers-- Definition of Provider- Outpatient Occupational Therapy (conforming amendment)	1866(e)	9337(c)(2) (B)	2034	158	---	---
Medicare--Agreements with Providers-- Payments for Ambulatory Surgery--Prevention of Unbundling of Outpatient Services--Sanctions	1866(g) New	9343(c)(3)	2040	---	---	316
Medicare--Emergency Medical Conditions and Women in Active Labor-- Refusal to Consent to Treatment (technical correction)	1867(b)(2)	9307(c)(4)	1996	---	---	---
Medicare--Emergency Medical Conditions and Women in Active Labor-- Refusal to Consent to Transfer (technical correction)	1867(b)(3)	9307(c)(4)	1996	---	---	---

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Medicare-- Determinations; Appeals--Permitting Review of Technical Denials	1869(a)	9313(b)(1) (A)	2003	417, 443, 444, 497	----	306
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Medicare-- Determinations; Appeals--Amount of Benefits Under Part B Entitlement to Hearing	1869(b)(1)(C)	9341(a)(1) (B)	2037	95, 158	----	306
Medicare-- Determinations; Appeals--Permitting Review of Technical Denials (technical amendment)	1869(b)(1)(C)	9313(b)(1) (B)(ii)	2003	497	----	----
Medicare-- Determinations; Appeals--Permitting Review of Technical Denials	1869(b)(1)(D) New	9313(b)(1) (B)(iii)	2003	417, 443, 444, 497	----	306
Medicare-- Determinations; Appeals--Permitting Provider Representation of Beneficiaries	1869(b)(1)	9313(a)(1)	2002	417, 443, 444, 497	145	306

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Medicare-- Determinations; Appeals--Minimum Amount in Controversy for Part A and B Appeals	1869(b)(2)	9341(a)(1) (C)	2037	95, 158	---	350
Medicare-- Determinations; Appeals--Part B-- Review of National Coverage Determination	1869(b)(3) New	9341(a)(1) (D)	2038	159	---	350
Medicare-- Determinations; Appeals--Part B-- Regulations or Instructions Prior to 1/1/81 Not Judicially Reviewable	1869(b)(4) New	9341(a)(1) (D)	2038	---	---	350
Medicare--Regulations-- 60-Day Notice for Proposed Regulations (technical amendment)	1871 Redesignated as 1871(a)	9321(e)(1)	2017	---	---	---
Medicare-- Regulations--60-Day Notice for Proposed Regulations	1871(b) New	9321(c)(1)	2017	---	---	311
Medicare--Studies and Recommendations-- Patient Outcome Assessment Research Program	1875(c) New	9316(a)	2006	71, 159	149	314
Medicare--Health Maintenance Organizations and Competitive Medical Plans--Explanation of Enrollee Rights	1876(c)(3)(E) New	9312(b)(1)	1999	441, 442, 498	---	301, 304
Medicare--Health Maintenance Organizations and Competitive Medical Plans--50% Non Medicare Enrollment--Reduction of Waiver	1876(f)(2)	9312(c)(1)	1999	161, 418, 441, 442	---	301, 302, 304

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Medicare--Health Maintenance Organizations and Competitive Medical Plans--50% Non Medicare Enrollment--Sanctions	1876(f)(3) New	9312(c)(2) (A)	2000	161, 441, 442, 498	---	302, 304
Medicare--Health Maintenance Organizations and Competitive Medical Plans--Prompt Payment of Claims	1876(g)(6) New	9312(d)(1)	2001	418, 441, 442, 498	---	301, 302, 305
Medicare--Health Maintenance Organizations and Competitive Medical Plans--50% Non Medicare Enrollment--Termination of Contracts	1876(i)(1)(C)	9312(c)(2) (B)	2000	---	---	305
Medicare--Health Maintenance Organizations and Competitive Medical Plans--Access to Financial Records and Disclosure of Internal Loans (technical amendment)	1876(i)(3)(C)	9312(e)(1) (A)	2001	499	---	---
Medicare--Health Maintenance Organizations and Competitive Medical Plans--Access to Financial Records and Disclosure of Internal Loans (technical amendment)	1876(i)(3)(C) Redesignated as (C)(i)	9312(e)(1) (B)	2001	499	---	---
Medicare--Health Maintenance Organizations and Competitive Medical Plans--Access to Financial Records	1876(i)(3)(C)(ii) New	9312(e)(1) (C)	2001	418, 441, 443, 499	---	301, 302, 305

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Medicare--Penalties--Permissible Conduct Pursuant to Group Purchasing Vendor Agreements (technical amendment)	1877(b)(3)(A)	9321(a)(1) (A)	2016	161, 500	----	----
Medicare--Penalties--Permissible Conduct Pursuant to Group Purchasing Vendor Agreements (technical amendment)	1877(b)(3)(B)	9321(a)(1) (B)	2016	161, 500	----	----
Medicare--Penalties--Permissible Conduct Pursuant to Group Purchasing Vendor Agreements	1877(b)(3)(C) New	9321(a)(1) (C)	2016	72, 162, 419, 445, 446, 500	----	309 310
Medicare--Beneficiary Liability Limitations--Extension of Waiver of Liability Provisions for Home Health Services	1879(a)	9305(g)(1) (B)	1991	417, 432, 435, 501	----	285, 288, 291, 292

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Medicare--Beneficiary Liability Limitations-- Home Health Services-- Deemed Notice of Coverage Denial	1879(a)	9305(g)(1) (C)	1992	432, 435, 501	----	285, 288, 291, 292
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Medicare--Beneficiary Liability Limitations-- Extension of Waiver of Liability Provisions-- Knowledge of Coverage Denial for Home Health Services	1879(c)	9305(g)(1) (D)	1992	432, 435, 501	----	285, 288, 291, 292
Medicare--Beneficiary Liability Limitations-- Provider Exercise of Individual's Rights (conforming amendment)	1879(d)	9341(a)(3)	2038	162	----	----
Medicare--Beneficiary Liability Limitations-- Home Health Agency-- Presumed Lack of Knowledge of Coverage Denial	1879(f) New	9305(g)(1) (E)	1992	432, 435, 501	----	285, 288, 291, 292
Medicare--Beneficiary Liability Limitations-- Coverage Denial--Home Health Agency	1879(g) New	9305(g)(1) (E)	1992	432, 435, 502	----	285, 288, 291, 292
Medicare--End Stage Renal Disease--Funding of Network Organization	1881(b)(7)	9355(j)(1)	2032	75, 163	----	338, 340, 341, 342
Medicare--End Stage Renal Disease-- Prospective Rate Determination Exception--Pediatric Facilities	1881(b)(7)	9335(a)(2) (A)	2029	76, 163	----	337, 338, 341

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Medicare--End Stage Renal Disease-- Reorganization of Network Areas and Organizations	1881(c)(1)(A)	9335(d)(1)	2030	78, 163, 419, 453, 454, 504	---	337, 339, 341
Medicare--End Stage Renal Disease-- Patient Representation on Council and Medical Review Boards	1881(c)(1)(B)	9335(e)	2031	164, 455, 505	---	338, 339, 341, 342
Medicare--End Stage Renal Disease-- Responsibilities of Network Organization-- Participation in Vocational Rehabilitation Programs	1881(c)(2)(A)	9335(f)(1)	2031	78, 164, 505	---	338, 339, 341, 342
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Medicare--End Stage Renal Disease-- Responsibilities of Network Organization (technical amendment)	1881(c)(2)(D) Redesignated as (G)	9335(f)(5)	2031	165, 505	---	---

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Medicare--End Stage Renal Disease-- Responsibilities of Network Organization-- Annual Report to Secretary--Encouragement of Vocational Rehabilitation	1881(c)(2)(E)	9335(f)(4)	2031	165, 455	---	338, 339, 341, 342
Medicare--End Stage Renal Disease-- Responsibilities (technical amendment)	1881(c)(2)(E) Redesignated as (H)	9335(f)(5)	2031	165	----	----
Medicare--End Stage Renal Disease-- Responsibilities of Network Organizations-- On-Site Reviews	1881(c)(2)(E) New	9335(f)(5)	2031	164 419, 455, 505	----	338, 339, 341, 342
Medicare--End Stage Renal Disease-- Responsibilities of Network Organization-- Data Collection for Reports	1881(c)(2)(F) New	9335(f)(5)	2031	78, 165, 419, 455, 505	---	338, 339, 341, 342
Medicare--End Stage Renal Disease--Failure to Follow Recommendations of Medical Board Review	1881(c)(3)	9335(g)	2031	165, 455, 505	---	338, 339, 341, 342
Medicare--End Stage Renal Disease-- Congressional Intent Re: Maximum Use of Vocational Rehabilitation Services	1881(c)(6)	9335(h)	2031	165, 455, 506	----	338, 339, 341, 342
Medicare--End Stage Renal Disease-- Establishment of Registry	1881(c)(7) New	9335(i)(1)	2032	78, 166, 455, 506	----	338, 340, 341, 342
Medicare--End Stage Renal Disease-- Protocols for Reuse of Dialyzer Filters	1881(f)(7)	9335(k)(1)	2033	166, 455, 507	----	338, 340, 341, 342

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Medicare--Payment for Inpatient Hospital Services--Certified Registered Nurse Anesthetist (conforming amendment)	1886(a)(4)	9320(g)(1)	2015	167	----	----
Medicare--Payment for Inpatient Hospital Services--Percentage Increase	1886(b)(3)(B) (i)(II)	9302(a)(1)	1982	416, 426, 507	137	274
Medicare--Payment for Inpatient Hospital Services--Standardized Amounts--Indirect Medical Education (technical correction)	1886(d)(2)(C)(i)	9307(c)(1) (A)	1995	508	----	----
Medicare--Payment for Inpatient Hospital Services--Standardized Amounts--Disproportionate Share (technical correction)	1886(d)(2) (C)(ii)	9307(c)(1) (B)	1995	508	----	----
Medicare--Payment for Inpatient Hospital Services--Standardized Amounts--Disproportionate Share (technical correction)	1886(d)(2) (C)(iii)	9307(c)(1) (B)	1995	508	----	----
Medicare--Payment for Inpatient Hospital Services--Standardized Amounts--Disproportionate Share (technical correction)	1886(d)(2) (C)(iv)	9307(c)(1) (B)	1995	508	----	----

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Medicare--Payment for Inpatient Hospital Services--Extension of Disproportionate Share Provisions in Rural Hospitals	1886(d)(2)(C)(iv)	9306(c)	1995	----	----	295
Medicare--Payment for Inpatient Hospital Services--Standardized Amounts--Indirect Medical Education (technical correction)	1886(d)(3)(A)	9307(c)(1)(A)	1995	508	----	----
Medicare--Payment for Inpatient Hospital Services--Standardized Amounts--Applicable Percentage Increase (conforming amendments)	1886(d)(3)(A)	9302(a)(2)(A)	1982	416, 426, 508	----	----
Medicare--Payment for Inpatient Hospital Services--Standardized Amounts--Computing Urban and Rural Averages	1886(d)(3)(A)	9302(c)	1983	----	137	275, 277, 279
Medicare--Payment for Inpatient Hospital Services--Separate Outlier Offsets--Urban and Rural	1886(d)(3)(B)	9302(b)(1)(A)	1982	----	137	275, 276, 278
Medicare--Payment for Inpatient Hospital Services--Separate Outlier Offsets--Urban and Rural	1886(d)(3)(B)	9302(b)(1)(B)	1982	----	137	275, 276, 278
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Medicare--Payment for Inpatient Hospital Services--Extension of Disproportionate Share Provisions in Rural Hospitals	1886(d)(3)(C)(ii)	9306(c)	1995	----	----	295
Medicare--Payment for Inpatient Hospital Services--Reducing for Disproportionate Share Payments (technical correction)	1886(d)(3)(C)(iii)	9307(c)(1)(B)	1995	509	----	----
Medicare--Payment for Inpatient Hospital Services--Percentage Increases--Annual Adjustment	1886(d)(4)(C)	9302(e)(1)	1984	416, 426	137	274
Medicare--Payment for Inpatient Hospital Services--Extension of Disproportionate Share Provisions in Rural Hospitals	1886(d)(5)(B)(ii)	9306(c)	1995	----	----	295
Medicare--Payment for Inpatient Hospital Services--Percentage Increases--Regional Referrals Center (technical amendment)	1886(d)(5)(C)(i) Redesignated as (i)(I)	9302(d)(1)(A)(i)	1983	----	----	----
Medicare--Payment for Inpatient Hospital Services--Prospective Payment System Coverage in Puerto Rico (conforming amendment)	1886(d)(5)(C)(i)(I) as Redesignated	9304(b)(1)	1988	----	----	----
Medicare--Payment for Inpatient Hospital Services--Percentage Increase--Regional Referral Centers	1886(d)(5)(C)(i)(II) New	9302(d)(1)(A)(ii)	1983	420, 437, 438	138	274

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Medicare--Payment for Inpatient Hospital Services--Prospective Payment System Coverage in Puerto Rico (conforming amendment)	1886(d)(5)(C) (ii)	9304(b)(2)	1988	---	---	---
Medicare--Payment for Inpatient Hospital Services--Percentage Increase--Extension of Sole Community Provider Provision	1886(d)(5)(C) (ii)	9302(e)(4)	1984	---	---	274, 275, 276, 278
Medicare--Payment for Inpatient Hospital Services--Certified Registered Nurse Anesthetist	1886(d)(5)(E) Stricken	9320(g)(2)	2015	83, 167	---	321
Medicare--Payment for Inpatient Hospital Services--Extension of Disproportionate Share Provisions in Rural Hospitals	1886(d)(5)(F) (i)	9306(c)	1995	---	---	295
Medicare--Payment for Inpatient Hospital Services--Amount in Large Rural Hospitals with Disproportionate Share of Low-Income Patients	1886(d)(5)(F) (iv)(I)	9306(b)(1)	1995	---	---	295
Medicare--Payment for Inpatient Hospital Services--Amount in Large Rural Hospitals with Disproportionate Share of Low-Income Patients	1886(d)(5)(F) (iv)(III)	9306(b)(2)	1995	---	---	295
Medicare--Payment for Inpatient Hospital Services-- Disproportionate Share In Large Rural Hospitals of Low-Income Patients	1886(d)(5)(F) (v)	9306(a)	1995	---	---	295

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Medicare--Payment for Inpatient Hospital Services-- Disproportionate Patient Percentage (technical correction)	1886(d)(5)(F) (vi)(I)	9307(c)(3) (A)	1996	511	----	----
Medicare--Payment for Inpatient Hospital Services-- Disproportionate Patient Percentage (technical correction)	1886(d)(5)(F) (vi)(I)	9307(c)(3) (B)	1996	511	----	----
Medicare--Payment for Inpatient Hospital Services-- Disproportionate Share of Low- Income Patients (technical correction)	1886(d)(5)(F) (vi)(I)	9307(c)(3) (B)	1996	511	----	----
Medicare--Payment for Inpatient Hospital Services--Prospective Payment System in Puerto Rico	1886(d)(9) New	9304(a)	1985	416, 430, 511	----	282
Medicare--Payment for Inpatient Hospital Services--Prospective Payment System in Puerto Rico--Budget Neutrality	1886(e)(1)(C) New	9304(c)	1988	416, 430	----	282
Medicare--Payment for Inpatient Hospital Services--Percentage Increase--Notice of Earlier Promulgation (technical amendment)	1886(e)(3) Redesignated as (3)(A)	9302(e)(3) (A)	1984	----	----	----
Medicare--Payment for Inpatient Hospital Services--Report of Prospective Payment Commission Date (conforming amendment)	1886(e)(3)(A)	9321(e)(2) (A)	2018	----	----	275, 276, 278

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Medicare--Payment for Inpatient Hospital Services--Percentage Increase (conforming amendment)	1886(e)(4)	9302(a)(2) (B)	1982	514	----	274, 275, 276, 277
Medicare--Payment for Inpatient Hospital Services--Percentage Increase--Clarifying Authority to Vary Rates (conforming amendment)	1886(e)(4)	9302(e)(2)	1984	514	----	277
Medicare--Payment for Inpatient Hospital Services--Percentage Increase--Recommendation (conforming amendment)	1866(sic) executed as 1886(e)(5)	9302(a)(2) (C)	1982	514	----	----
Medicare--Payment for Inpatient Hospital Services--Percentage Increase--Publication in the Federal Register (conforming amendment)	1886(e)(5)(A)	9321(e)(2) (B)	2018	514	----	----
Medicare--Payment for Inpatient Hospital Services--Capital-- Related Costs	1886(g)(3) New	9303(a)	1985	416, 428, 514	139	279
Medicare--Payment for Inpatient Hospital Services--Capital-- Related Costs--Puerto Rico Hospitals	1886(g)(3)(A)	9303(b)	1985	----	----	282
Medicare--Payment for Inpatient Hospital Services--Direct Costs of Graduate Medical Education--Time in Outpatient Settings	1886(h)(4)(E) New	9314(a)	2005	69, 168	143	311

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Medicaid--State Plans--Laboratory Services--Certified Registered Nurse Anesthetist (technical amendment)	1902(a)(9)(C)	9320(h)(3)	2016	169	----	----
Medicaid--State Plans--Eligibility of Qualified Severely Impaired--Categorically Needy	1902(a)(10)(A) (i)(II)	9404(a)	2057	106, 173	----	391
Medicaid--State Plans--New Categorically Needy Group--Poor Pregnant Women, Infants and Children (technical amendment)	1902(a)(10)(A) (ii)(VII)	9401(a)(1)	2050	174	----	----
Medicaid--State Plans--New Categorically Needy Group--Poor Pregnant Women, Infants and Children (technical amendment)	1902(a)(10)(A) (iv)(VII)	9401(a)(2)	2050	174	----	----
Medicaid--State Plans--New Categorically Needy Group--Elderly and Disabled Poor (technical amendment)	1902(a)(10)(A) (ii)(VIII)	9402(a)(1) (A)	2052	174	----	----
Medicaid--State Plans--New Categorically Needy Group--Poor Pregnant Women, Infants and Children	1902(a)(10)(A) (ii)(IX) New	9401(a)(3)	2050	98, 174	151	391
Medicaid--State Plans--New Categorically Needy Group--Elderly and Disabled Poor (technical amendment)	1902(a)(10)(A) (ii)(IX)	9402(a)(1) (B)	2052	174	----	----

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Medicaid--State Plans--New Categorically Needy Group--Elderly and Disabled Poor	1902(a)(10)(A) (ii)(X) New	9401(a)(1)	2052	102, 174	152	394
Medicare--State Plans--Coverage of Poor Medicare Beneficiaries for Cost- Sharing Expenses (conforming amendment)	1902(a)(10)(C)	9403(g)(1)	2055	174	----	----
Medicaid--State Plans--Care in Mental Institutions-- Respiratory Care (conforming amendment)	1902(a)(10)(C)(iv)	9408(c)(3)	2061	174	----	----
Medicaid--State Plans--Coverage of Poor Medicare Beneficiaries for Cost- Sharing Expenses (technical amendment)	1902(a)(10)(C)	9403(a)(1)	2053	174	----	----
Medicaid--State Plans--Coverage of Poor Medicare Beneficiaries for Cost- Sharing Expenses (technical amendment)	1902(a)(10)(D)	9403(a)(2)	2053	175	----	----
Medicaid--State Plans--Coverage of Poor Medicare Beneficiaries for Cost- Sharing Expenses	1902(a)(10)(E) New	9403(a)(3)	2053	105, 175	152	395
Medicaid--State Plans--Limited Benefits for Newly Eligible Pregnant Women (technical amendment)	1902(a)(10)(V)	9401(c)(1)	2051	175	----	----

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
Medicaid--State Plans--Limited Benefits for Newly Eligible Pregnant Women (technical amendment)	1902(a)(10)(VI)	9401(c)(2)	2051	176	----	----
Medicaid--State Plans--Limited Medicare Gap-Filling Benefits (technical amendment)	1902(a)(10)(VI)	9403(c)(1)	2054	176	----	----
Medicaid--State Plans--Limited Benefits for Newly Eligible Pregnant Women	1902(a)(10)(VII) New	9401(c)(2)	2051	100, 176	153	393
Medicaid--State Plans--Limited Medicare Gap-Filling Benefits (technical amendment)	1902(a)(10)(VII)	9403(c)(2)	2054	176	----	----
Medicaid--State Plans--Limited Medicare Gap-Filling Benefits	1902(a)(10)(VIII) New	9403(c)(2)	2054	102, 176	152	395
Medicaid--State Plans--Ventilator Services--Waiver of Comparability (technical amendment)	1902(a)(10)(VIII)	9408(b)(1)	2061	----	----	----
Medicaid--State Plans--Ventilator Services--Waiver of Comparability (technical amendment)	1902(a)(10)(VIII)	9408(b)(2)	2061	----	----	----
Medicaid--State Plans--Ventilator Services--Waiver of Comparability	1902(a)(10)(IX) New	9408(b)(2)	2061	----	152	413
Medicaid--State Plans--Hospice Care for Dual Eligibles (conforming amendment)	1902(a)(13)(D)	9435(b)(1)	2069	----	----	----

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
Medicaid--State Plans--Poor Medicare Beneficiaries Copayments (conforming amendment)	1902(a)(15)	9403(g)(4) (A)	2056	176	---	---
Medicaid--State Plans--Pregnant Women, Infants and Children-- Resource Standard or Methodology (conforming amendment)	1902(a)(17)	9401(e)(1)	2052	176	151	---
Medicaid--State Plans--Health Maintenance Organization Quality Review (technical amendment)	1902(a)(30)(B)	9431(a)(1)	2066	---	---	---
Medicaid--State Plans--Health Maintenance Organization Quality Review	1902(a)(30)(C) New	9431(a)(2)	2066	118, 177	---	356
Medicaid--State Plans--Optional Presumptive Eligibility Period for Pregnant Women (technical amendment)	1902(a)(45)	9407(a)(1)	2058	---	---	---
Medicaid--State Plans--Optional Presumptive Eligibility Period for Pregnant Women (technical amendment)	1902(a)(46)	9407(a)(2)	2058	---	---	---
Medicaid--State Plans--Optional Presumptive Eligibility Period for Pregnant Women	1902(a)(47) New	9407(a)(3)	2058	---	153	393
Medicaid--State Plans--Payment for Aliens Under Medicaid (conforming amendment)	1902(a)	9406(b)	2058	177	---	399

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
Medicaid--State Plans--Eligibility of Homeless Individuals	1902(b)(2)	9405	2057	108, 178	----	398
Medicaid--State Plans--Health Maintenance Organization Quality Review (conforming amendment)	1902(d)	9431(b)(1)	2066	178	----	356
Medicaid--State Plans--Continuing Eligibility of Certain Pregnant Women and Children	1902(e)(6) New	9401(d)	2051	98, 178	----	391
Medicaid--State Plans--Continued Treatment of Minor Inpatients Beyond the Minimum Age	1902(e)(7) New	9401(d)	2051	98, 178	----	391
Medicaid--State Plans--Continued Eligibility of a "Qualified Medicare Beneficiary"	1902(e)(8) New	9403(f)(2)	2055	105, 178	152	395
Medicaid--State Plans--Home Respiratory Care Services	1902(e)(9) New	9408(a)	2060	----	152	413
Medicaid--State Plans--Clarification of Policy re: Hospitals Service Disproportionate Share of Low-Income Patients with Special Needs	1902(h) New	9433(a)	2068	179	----	409
Medicaid--State Plans--Respiratory Care Services (technical amendment)	1902(j)	9408(c)(2)	2061	179	----	----
Medicaid--State Plans--Optional Coverage of Poor Pregnant Women, Infants and Children	1902(l) New	9401(b)	2050	179	151	391

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
Medicaid--State Plans--Categorically Needy Groups--Elderly and Disabled Poor	1902(m) New	9402(a)(2)	2052	180	152	394
Medicaid--State Plans--Required Coverage of Certain Pregnant Women and Children	1902(m)(3) New	9402(b)	2053	181	151	394
Medicaid--State Plans--Required Coverage of Certain Pregnant Women and Children for Medicare Cost Sharing--Income Standard (conforming amendment)	1902(m)(3)	9403(f)(1) (A)	2055	---	---	---
Medicaid--State Plans--Required Coverage of Certain Pregnant Women and Children--Income Standard	1902(m)(4) New	9402(b)	2053	181	151	395
Medicaid--State Plans--Required Coverage of Certain Pregnant Women and Children for Medicare Cost Sharing-- Income Standard	1902(m)(5) New	9403(f)(1) (B)	2055	---	152	395
Medicaid--State Plans--Medicare Cost- Sharing Amounts of Payment	1902(n) New	9403(e)	2054	181	152	395
Medicaid--Payment to States--Medicare Part A Deductibles (conforming amendment)	1903(a)(1)	9403(g)(2) (A)	2055	181	---	---
Medicaid--Payment to States--Medicare Part B Premiums (conforming amendment)	1903(a)(1)	9403(g)(2) (B)	2055	181	---	---

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
Medicaid--Payment to States--Medical Deductibles and Premiums for "Qualified Medicare Beneficiaries" (technical amendment)	1903(a)(1)(A)	9403(g)(2)(C)	2055	181	----	----
Medicaid--Payment to States--Medicare Deductibles and Premiums for "Qualified Medicare Beneficiaries" (conforming amendment)	1903(a)(1)(B) New	9403(g)(2)(C)	2055	181	----	----
Medicaid--Payment to States--Medicare Deductibles and Premiums for "Qualified Medicare Beneficiaries" (technical amendment)	1903(a)(1)(B) Redesignated as (C)	9403(g)(2)(C)	2055	181	----	----
Medicaid--Payment to States--Quality Review of Health Maintenance Organization Services (conforming amendment)	1903(a)(3)(C)	9431(b)(2)	2066	182	----	----
Medicaid--Payment to States--Coverage of Poor Pregnant Women, Infants and Children (conforming amendment)	1903(f)(4)	9401(e)(2)	2052	182	----	----
Medicaid--Payment to States--State Contracts with Health Maintenance Organizations--Secretarial Approval of High Cost Contracts	1903(m)(2)(A) (iii)	9434(a)(2)	2069	183	----	410
Medicaid--Payment to States--Health Maintenance Organizations--Disclosure of Interlocking Relationships (technical amendment)	1903(m)(2)(A) (vi)	9434(a)(1)(A)(i)	2068	183	----	----

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
Medicaid--Payment to States--Health Maintenance Organizations--Disclosure of Interlocking Relationships (technical amendment)	1903(m)(2)(A) (vii)	9434(a)(1) (A)(ii)	2068	183	----	----
Medicaid--Payment to States--Health Maintenance Organizations--Disclosure of Interlocking Relationships	1903(m)(2)(A) (viii) New	9434(a)(1) (A)(iii)	2068	183	----	409
Medicaid--Payment to States--Unqualified Health Maintenance Organizations--Disclosure of Interlocking Relationships	1903(m)(4) New	9434(a)(1) (B)	2068	183	----	409
Medicaid--Payment to States--Health Maintenance Organization--Civil Money Penalties for Deficient Care	1903(m)(5) New	9434(b)	2069	----	----	410
Medicaid--Payment to States--Erroneous Excess Payments-- Ambulatory Prenatal Care (conforming amendment)	1903(u)(1)(D) (V) New	9407(c)	2060	----	----	393
Medicaid--Payment to States--Payment for Aliens	1903(v) New	9406(a)	2057	----	----	399
Medicaid--Definitions-- Medical Assistance-- Medicare Cost-Sharing-- Timing of Benefits	1905(a)	9403(g)(3)	2056	184	----	396
Medicaid--Definitions-- Medical Assistance-- Respiratory Care Services (technical amendment)	1905(a)(19)	9408(c)(1) (A)	2061	185	----	----

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
Medicaid--Definitions-- Medical Assistance-- Respiratory Care Services (technical amendment)	1905(a)(20) Redesignated as (21)	9408(c)(1) (B)	2061	185	----	----
Medicaid--Definitions-- Medical Assistance-- Respiratory Care Services	1905(a)(20) New	9408(c)(1) (C)	2061	----	152	413
Medicaid--Definitions-- Hospice Care for Dual Eligibles	1905(o)(3) New	9435(b)(2)	2070	----	----	412
Medicaid--Definitions-- Qualified Medicare Beneficiary	1905(p)	9403(b)	2053	105, 185	152	395
Medicaid--Definitions-- Medicare Cost--Sharing	1905(p)(3) New	9403(d)	2054	105, 185	152	395
Medicaid--Definitions-- Qualified Severly Impaired Individuals	1905(q) New	9404(b)	2056	106, 185	----	396
Medicaid--Waiver of Requirements-- Laboratory Services-- Certified Registered Nurse Anesthetist (technical amendment)	1915(a)(1)(B) (ii)(I)	9320(h)(3)	2016	170	----	----
Medicaid--Waiver of Requirements--Home or Community Based Services in Lieu of Inpatient Hospital Services	1915(c)(1)	9411(a)(1) (A)	2061	111	----	400
Medicaid--Waiver of Requirements--Home or Community Based Services for Ventilator Support Dependents	1915(c)(1)	9411(a)(1) (B)	2061	111	----	401
Medicaid--Waiver of Requirements--Home or Community Based Services in Lieu of Inpatient Hospital Services	1915(c)(2)(B) (i)	9411(a)(2) (A)	2061	111	----	400

<u>Subject</u>	<u>S.S. Act Section</u>	<u>P.L. Section</u>	<u>100 Stat.</u>	<u>H.Rep. 99-727</u>	<u>S.Rep. 99-348</u>	<u>H.C.Rep. 99-1012</u>
Medicaid--Waiver of Requirements--Home or Community Based Services in Lieu of Inpatient Hospital Services	1915(c)(2)(B)	9411(a)(2) (B)	2061	111	---	400
Medicaid--Waiver of Requirements--Home or Community Based Services--Waiver of Comparability	1915(c)(3)	9411(c)	2062	111, 186	---	400
Medicaid--Waiver of Requirements--Home or Community Based Services--Other Services to Patients with Chronic Mental Illness	1915(c)(4)(B)	9411(d)	2062	114, 187	---	401
Medicaid--Waiver of Requirements--Home or Community Based Services--Estimating Expenditures for Special Patients Separately from Others	1915(c)(7)	9411(a)(3)	2061	111, 187	---	400
Medicaid--Waiver of Requirements--Home or Community Based Services--Case Management Services Limitations	1915(g)(1)	9411(b)	2062	111, 189	---	400
Medicaid--Use of Fees, Premiums, and Charges--No Copayments for Poor Medicare Beneficiaries (conforming amendment)	1916(a)	9403(g)(4) (B)	2056	105, 189	---	---
Medicaid--Use of Fees, Premiums, and Charges--No Copayments for Poor Medicare Beneficiaries (conforming amendment)	1916(b)	9403(g)(4) (B)	2056	105, 189	---	---
Medicaid--Presumptive Eligibility for Pregnant Women (technical amendment)	1920 Redesignated as 1921	9407(b)	2058	---	---	---
Medicaid--Presumptive Eligibility for Pregnant Women	1920 New	9407(b)	2058	---	153	393

PUBLIC LAW 99-509—OCT. 21, 1986

OMNIBUS BUDGET RECONCILIATION
ACT OF 1986

***Public Law 99-509**
99th Congress

An Act

Oct. 21, 1986
 [H.R. 5300]

Omnibus Budget
 Reconciliation
 Act of 1986.

To provide for reconciliation pursuant to section 2 of the concurrent resolution on the budget for fiscal year 1987.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Omnibus Budget Reconciliation Act of 1986”.

(b) **TABLE OF CONTENTS.**—

Title I. Agriculture programs.

Title II. Banking and housing programs.

Title III. Energy and environmental programs.

Title IV. Transportation and related programs.

Title V. Maritime programs.

Title VI. Civil service, Postal Service, and governmental affairs generally.

Title VII. Fiscal procedures.

Title VIII. Revenues, trade, and related programs.

Title IX. Income security, medicare, medicaid, and maternal and child health programs.

TITLE I—AGRICULTURAL PROGRAMS

Subtitle A—Sale of Notes

SEC. 1001. SALE OF RURAL DEVELOPMENT NOTES.

(a) **SALES REQUIRED.**—The Secretary of Agriculture, under such terms as the Secretary may prescribe, shall sell notes and other obligations held in the Rural Development Insurance Fund established under section 309A of the Consolidated Farm and Rural Development Act in such amounts as to realize net proceeds to the Government of not less than—

- (1) \$1,000,000,000 from such sales during fiscal year 1987,
- (2) \$552,000,000 from such sales during fiscal year 1988, and
- (3) \$547,000,000 from such sales during fiscal year 1989.

(b) **NONRECOURSE SALES.**—The second sentence of section 309A(e) of the Consolidated Farm and Rural Development Act (7 U.S.C. 1929a(e)) is amended by—

- (1) inserting “and other obligations” after “Notes”; and
- (2) striking out the period at the end thereof and inserting in lieu thereof the following: “, including sale on a nonrecourse basis. The Secretary and any subsequent purchaser of such notes or other obligations sold by the Secretary on a nonrecourse basis shall be relieved of any responsibilities that might have been imposed had the borrower remained indebted to the Secretary.”.

(c) **CONTRACT PROVISIONS.**—Consistent with section 309A(e) of the Consolidated Farm and Rural Development Act, as amended by subsection (b), any sale of notes or other obligations, as described in

*Note: This is a subsequently typeset print of the hand enrollment which was signed by the President on October 21, 1986.

7 USC 1929a
 note.

7 USC 1929a.

7 USC 1929a
 note.

ment shortfall. Such term shall not include the Department of Defense Military Retirement Fund.

(c) **INTEREST PAYMENT SHORTFALL.**—For purposes of this section, the term “interest payment shortfall” means, with respect to any fund, the reduction in the interest which would have been earned by such fund during the period beginning with September 30, 1986, and ending with the date of the enactment of this Act as the result of noninvestments, redemptions, and disinvestments with respect to such fund which occurred during such period and which would not have occurred if H.J. Res. 668 (99th Congress, 2d Session), as passed by the House of Representatives on June 26, 1986, had been enacted into law on September 30, 1986. Such amount shall be reduced by any payment to such fund under any other provision of law in respect of such lost interest.

SEC. 8203. RESTORATION OF DEPARTMENT OF DEFENSE MILITARY RETIREMENT FUND.

The Secretary of the Treasury shall immediately issue to the Department of Defense Military Retirement Fund obligations under chapter 31 of title 31, United States Code, which such Secretary, in consultation with the Secretary of Defense, determines would have been issued to such fund on October 1, 1986, if H.J. Res. 668 (99th Congress, 2d session), as passed by the House of Representatives on June 26, 1986, had been enacted into law on September 30, 1986. Such obligations shall be market-based special obligations issued at prices, including accrued interest, prevailing for such obligations on October 1, 1986. Such obligations shall be issued as of October 1, 1986, and the fund shall earn interest on such obligations beginning on October 1, 1986. Such obligations shall be substituted for obligations which are held by such fund on the date of the enactment of this Act (and any uninvested balance on such date in such fund shall be reduced) in a manner which will ensure that, after such substitution (and reduction), the holdings of such fund will replicate to the maximum extent practicable the holdings which would have been held by such fund on such date if such H.J. Res. 668 had been enacted into law on September 30, 1986.

31 USC 3101 *et seq.*

TITLE IX—INCOME SECURITY, MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH PROGRAMS

Subtitle A—OASDI provisions
 Subtitle B—Provisions relating to public assistance
 Subtitle C—Older Americans pension benefits
 Subtitle D—Provisions relating to medicare
 Subtitle E—Medicaid and maternal and child health
 Subtitle F—Provision relating to access to health care

Subtitle A—OASDI Provisions

SEC. 9001. ELIMINATION OF 3-PERCENT TRIGGER FOR COST-OF-LIVING INCREASES.

(a) **ELIMINATION OF TRIGGER.**—Section 215(i)(1)(B) of the Social Security Act is amended by striking out “with respect to which the applicable increase percentage is 3 percent or more” and inserting

42 USC 415.

in lieu thereof “with respect to which the applicable increase percentage is greater than zero”.

(b) CONFORMING AMENDMENTS.—

42 USC 415.

(1) IN CURRENT LAW.—Section 215(i) of such Act is further amended—

(A)(i) by striking out clause (i) in paragraph (2)(C) and redesignating clauses (ii) and (iii) of such paragraph as clauses (i) and (ii), respectively; and

(ii) by striking out “under clause (ii)” in clause (ii) of such paragraph as so redesignated and inserting in lieu thereof “under clause (i)”;

42 USC 1305
note

(B) by inserting “and by section 9001 of the Omnibus Budget Reconciliation Act of 1986” after “Social Security Amendments of 1983” in paragraph (4); and

(C) by striking out “because the wage increase percentage was less than 3 percent” in paragraph (5)(A)(i) and inserting in lieu thereof “because there was no wage increase percentage greater than zero”.

(2) IN APPLICABLE FORMER LAW.—Section 215(i) of such Act, as in effect in December 1978 and applied in certain cases under the provisions of such Act in effect after December 1978, is amended—

(A) by striking out “, by not less than 3 per centum,” in paragraph (1)(B); and

(B) by striking out “(C)(i) Whenever” and all that follows down through “(ii) Whenever” in paragraph (2)(C) and inserting in lieu thereof “(C) Whenever”.

42 USC 1395r.

(c) TECHNICAL AMENDMENT TO SMI PROGRAM.—Section 1839(f)(2)(A) of such Act is amended to read as follows:

42 USC 402, 423.

“(A) the monthly premium amount determined under subsection (a)(2) for that January reduced by the amount (if any) by which the monthly benefit under section 202 or 223 for that November, after the deduction of the premium (disregarding subsection (b)) for that individual for that December and after rounding under section 215(g), would exceed the monthly benefit under section 202 or 223 for that December, after the deduction of the monthly premium amount determined under subsection (a)(2) (disregarding subsection (b)) for that individual for that January and after rounding under section 215(g), or”.

42 USC 415.

42 USC 415 note.

(d) EFFECTIVE DATE.—(1) Except as provided in paragraphs (2) and (3), the amendments made by this section shall apply with respect to cost-of-living increases determined under section 215(i) of the Social Security Act (as currently in effect, and as in effect in December 1978 and applied in certain cases under the provisions of such Act in effect after December 1978) in 1986 and subsequent years.

(2) The amendments made by paragraphs (1)(A) and (2)(B) of subsection (b) shall apply with respect to months after September 1986.

(3) The amendment made by subsection (c) shall apply with respect to monthly premiums (under section 1839 of the Social Security Act) for months after December 1986.

SEC. 9002. DEPOSITS OF SOCIAL SECURITY CONTRIBUTIONS BY STATE AND LOCAL GOVERNMENT EMPLOYERS.

26 USC 3126,
3127;
post, p. 2095;
26 USC 3121 et
seq.

(a) RETURNS AND PAYMENTS.—(1) Subchapter C of chapter 21 of the Internal Revenue Code of 1954 is amended by redesignating

section 3126 as section 3127, and by inserting after section 3125 the following new section:

"SEC. 3126. RETURN AND PAYMENT BY GOVERNMENTAL EMPLOYER.

Wages.
26 USC 3126.

"If the employer is a State or political subdivision thereof, or an agency or instrumentality of any one or more of the foregoing, the return of the amount deducted and withheld upon any wages under section 3101 and the amount of the tax imposed by section 3111 may be made by any officer or employee of such State or political subdivision or such agency or instrumentality, as the case may be, having control of the payment of such wages, or appropriately designated for that purpose."

(2) The table of sections for subchapter C of chapter 21 of such Code is amended by striking out the last item and inserting in lieu thereof the following:

"Sec. 3126. Return and payment by governmental employer.

"Sec. 3127. Short title."

(b) TREATMENT OF SERVICE UNDER SECTION 218 AGREEMENTS AS EMPLOYMENT PERFORMED BY EMPLOYEES.—

(1) SERVICE TREATED AS EMPLOYMENT.—(A) Section 3121(b)(7) of such Code is amended—

(i) by striking out "; or" at the end of subparagraph (C) and inserting in lieu thereof a comma;

(ii) by striking out the semicolon at the end of subparagraph (D) and inserting in lieu thereof "; or"; and

(iii) by adding after subparagraph (D) the following new subparagraph:

"(E) service included under an agreement entered into pursuant to section 218 of the Social Security Act;"

Infra.

(B) Section 1402(b) of such Code is amended by striking out "under an agreement entered into pursuant to the provisions of section 218 of the Social Security Act (relating to coverage of State employees), or" in the flush sentence immediately following paragraph (2).

(2) INDIVIDUAL PERFORMING SERVICES TREATED AS EMPLOYEE.—

(A) Section 3121(d) of such Code is amended by redesignating paragraph (3) as paragraph (4), and by inserting after paragraph (2) the following new paragraph:

"(3) any individual who performs services that are included under an agreement entered into pursuant to section 218 of the Social Security Act; or"

(B) Section 3306(i) of such Code is amended by striking out "subparagraphs (B) and (C) of paragraph (3)" and inserting in lieu thereof "paragraph (3) and subparagraphs (B) and (C) of paragraph (4)".

(c) CONFORMING AMENDMENTS IN SOCIAL SECURITY ACT.—(1) Subsections (e), (h), (i), (j), (q), (r), (s), (t), and (w) of section 218 of the Social Security Act are repealed; and subsections (f), (g), (k), (l), (m), (n), (o), (p), and (u) of such section are redesignated as subsections (e), (f), (g), (h), (i), (j), (k), (l), and (m), respectively. 42 USC 418.

(2)(A) Section 205(c)(1)(D)(i) of such Act is amended by inserting "(as in effect prior to December 31, 1986)" after "section 218(e)". 42 USC 405.

(B) Section 205(c)(5)(F)(iii) of such Act is amended—

(i) by inserting "(as in effect prior to December 31, 1986)" after "section 218"; and

(ii) by inserting "(as so in effect)" after "subsection (q) of such section".

42 USC 418.

(C) Section 218(d)(6) of such Act is amended—

(i) by striking out “subsection (f)” in subparagraph (A) and inserting in lieu thereof “subsection (e)”; and

(ii) by striking out “subsection (f)(1)” in subparagraph (F) and inserting in lieu thereof “subsection (e)(1)”.

(D) Section 218(d)(8)(D) of such Act is amended by striking out “subsection (p)” and inserting in lieu thereof “subsection (l)”.

(E) Section 218(e)(1) of such Act (as redesignated by paragraph (1) of this subsection) is amended by striking out “Except as provided in subsection (e)(2), any agreement” and inserting in lieu thereof “Any agreement”.

42 USC 424a.

(F) Section 224(a)(2)(B) of such Act is amended by striking out “section 218(k)” and inserting in lieu thereof “section 218(g)”.

Wages.

Taxes.

42 USC 418 note.

(d) **EFFECTIVE DATE.**—The amendments made by this section are effective with respect to payments due with respect to wages paid after December 31, 1986, including wages paid after such date by a State (or political subdivision thereof) that modified its agreement pursuant to the provisions of section 218(e)(2) of the Social Security Act prior to the date of the enactment of this Act; except that in cases where, in accordance with the currently applicable schedule, deposits of taxes due under an agreement entered into pursuant to section 218 of the Social Security Act would be required within 3 days after the close of an eighth-monthly period, such 3-day requirement shall be changed to a 7-day requirement for wages paid prior to October 1, 1987, and to a 5-day requirement for wages paid after September 30, 1987, and prior to October 1, 1988. For wages paid prior to October 1, 1988, the deposit schedule for taxes imposed under sections 3101 and 3111 shall be determined separately from the deposit schedule for taxes withheld under section 3402 if the taxes imposed under sections 3101 and 3111 are due with respect to service included under an agreement entered into pursuant to section 218 of the Social Security Act.

26 USC 3101,
3111.

26 USC 3402.

Subtitle B—Provisions Relating to Public Assistance

SEC. 9101. TARGETING UNDER INCOME AND ELIGIBILITY VERIFICATION SYSTEM.

State and local
governments.
42 USC 1520b-7.

Section 1137(a)(4)(C) of the Social Security Act is amended by inserting after “payments” the following: “, and no State shall be required to use such information to verify the eligibility of all recipients”.

SEC. 9102. ANNUAL CALCULATION OF FEDERAL PERCENTAGE FOR AFDC PURPOSES.

42 USC 1301
note.
Ante, p. 219.

Section 9528(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (as added by section 9421(a) of this Act) is amended (effective as provided in section 9421(b))—

State and local
governments.

42 USC 603,
1396b.

(1) by striking out “payment to a State under section 1903” and inserting in lieu thereof “payments to States under sections 403 and 1903”; and

(2) by inserting “with respect to either such section” after “shall not apply to a State”.

SEC. 9103. REQUIREMENT OF STATUTORILY PRESCRIBED PROCEDURES TO PROHIBIT RETROACTIVE MODIFICATION OF CHILD SUPPORT ARREARAGES.

(a) **IN GENERAL.**—Section 466(a) of the Social Security Act is amended by inserting immediately after paragraph (8) the following new paragraph:

State and local governments.
42 USC 666.

“(9) Procedures which require that any payment or installment of support under any child support order, whether ordered through the State judicial system or through the expedited processes required by paragraph (2), is (on and after the date it is due)—

“(A) a judgment by operation of law, with the full force, effect, and attributes of a judgment of the State, including the ability to be enforced,

“(B) entitled as a judgment to full faith and credit in such State and in any other State, and

“(C) not subject to retroactive modification by such State or by any other State;

except that such procedures may permit modification with respect to any period during which there is pending a petition for modification, but only from the date that notice of such petition has been given, either directly or through the appropriate agent, to the obligee or (where the obligee is the petitioner) to the obligor.”.

(b) **EFFECTIVE DATE.**—(1) Except as provided in paragraph (2), the amendment made by subsection (a) shall become effective on the date of the enactment of this Act.

42 USC 666 note.

(2) In the case of a State with respect to which the Secretary of Health and Human Services has determined that State legislation is required in order to conform the State plan approved under part D of title IV of the Social Security Act to the requirements imposed by the amendment made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such part solely by reason of its failure to meet the requirements imposed by such amendment prior to the beginning of the fourth month beginning after the end of the first session of the State legislature which ends on or after the date of the enactment of this Act. For purposes of the preceding sentence, the term “session” means a regular, special, budget, or other session of a State legislature.

State and local governments.

42 USC 651.

Subtitle C—Older Americans Pension Benefits

SEC. 9201. PROHIBITION AGAINST DISCRIMINATION ON THE BASIS OF AGE IN EMPLOYEE PENSION BENEFIT PLANS.

Section 4 of the Age Discrimination in Employment Act of 1967 (29 U.S.C 623) is amended by adding at the end the following new subsection:

“(i)(1) Except as otherwise provided in this subsection, it shall be unlawful for an employer, an employment agency, a labor organization, or any combination thereof to establish or maintain an employee pension benefit plan which requires or permits—

“(A) in the case of a defined benefit plan, the cessation of an employee’s benefit accrual, or the reduction of the rate of an employee’s benefit accrual, because of age, or

(A) the later of—

- (i) January 1, 1988, or
- (ii) the date on which the last of such collective bargaining agreements terminate (determined without regard to any extension thereof after February 28, 1986), or

(B) January 1, 1990.

(b) **APPLICABILITY OF AMENDMENTS RELATING TO NORMAL RETIREMENT AGE.**—The amendments made by section 9203 shall apply only with respect to plan years beginning on or after January 1, 1988, and only with respect to service performed on or after such date.

(c) **PLAN AMENDMENTS.**—If any amendment made by this subtitle requires an amendment to any plan, such plan amendment shall not be required to be made before the first plan year beginning on or after January 1, 1989, if—

(1) during the period after such amendment takes effect and before such first plan year, the plan is operated in accordance with the requirements of such amendment, and

(2) such plan amendment applies retroactively to the period after such amendment takes effect and such first plan year. A pension plan shall not be treated as failing to provide definitely determinable benefits or contributions, or to be operated in accordance with the provisions of the plan, merely because it operates in accordance with this subsection.

Regulations.

(d) **INTERAGENCY COORDINATION.**—The regulations and rulings issued by the Secretary of Labor, the regulations and rulings issued by the Secretary of the Treasury, and the regulations and rulings issued by the Equal Employment Opportunity Commission pursuant to the amendments made by this subtitle shall each be consistent with the others. The Secretary of Labor, the Secretary of the Treasury, and the Equal Employment Opportunity Commission shall each consult with the others to the extent necessary to meet the requirements of the preceding sentence.

(e) **FINAL REGULATIONS.**—The Secretary of Labor, the Secretary of the Treasury, and the Equal Employment Opportunity Commission shall each issue before February 1, 1988, such final regulations as may be necessary to carry out the amendments made by this subtitle.

Subtitle D—Provisions Relating to Medicare

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PART 1—PROVISIONS RELATING TO MEDICARE PART A ONLY

SEC. 9301. CHANGES IN INPATIENT HOSPITAL DEDUCTIBLE.

(a) **IN GENERAL.**—Section 1813(b) of the Social Security Act (42 U.S.C. 1395e(b)) is amended to read as follows:

“(b)(1) The inpatient hospital deductible for 1987 shall be \$520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the applicable percentage increase (as defined in section 1886(b)(3)(B)) which is applied under section 1886(d)(3)(A) for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of \$4 shall be rounded to the nearest multiple of \$4 (or, if it is midway between two multiples of \$4, to the next higher multiple of \$4).

“(2) The Secretary shall promulgate the inpatient hospital deductible and all coinsurance amounts under this section between September 1 and September 15 of the year preceding the year to which they will apply.

“(3) The inpatient hospital deductible for a year shall apply to—

“(A) the deduction under the first sentence of subsection (a)(1) for the year in which the first day of inpatient hospital services occurs in a spell of illness, and

Ante, p. 153.

Post, p. 1983.

“(B) to the coinsurance amounts under subsection (a) for inpatient hospital services and post-hospital extended care services furnished in that year.”.

42 USC 1395e
note.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to inpatient hospital services and post-hospital extended care services furnished on or after January 1, 1987, and to the monthly premium (under part A of title XVIII of the Social Security Act) for months beginning with January 1987.

42 USC 1395c.
42 USC 1395e
note.

(c) **PROMULGATION OF NEW DEDUCTIBLE.**—The Secretary of Health and Human Services shall provide, within 30 days after the date of the enactment of this Act, for the publication of the inpatient hospital deductible, the coinsurance amounts for inpatient hospital services and post-hospital extended care services and the monthly part A premiums for 1987, as modified under the amendment made by subsection (a).

SEC. 9302. APPLICABLE PERCENTAGE INCREASE IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES.

(a) APPLICABLE PERCENTAGE INCREASE.—

(1) **IN GENERAL.**—Subclause (II) of section 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended to read as follows:

“(II) for fiscal year 1987, 1.15 percent, and for fiscal year 1988, the market basket percentage increase (as defined in clause (ii)) minus 2.0 percentage points, and”.

Ante, p. 154; *post*,
p. 1983.

(2) **CONFORMING AMENDMENTS.**—(A) Section 1886(d)(3)(A) of such Act is amended by striking “and 1986” and inserting “, 1986, 1987, and 1988”.

(B) Section 1886(e)(4) of such Act is amended by striking “determine for each fiscal year (beginning with fiscal year 1987)” and inserting “recommend for fiscal year 1988 an appropriate change factor for inpatient hospital services for discharges in that fiscal year and shall determine for each subsequent fiscal year”.

(C) Section 1886(e)(5) of such Act is amended by inserting “recommendation or” before “determination” each place it appears.

42 USC 1395ww
note.

(3) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after October 1, 1986 and, for purposes of section 1886(d) of the Social Security Act, for cost reporting periods beginning and discharges occurring on or after October 1, 1986.

(b) SEPARATE OUTLIER OFFSETS FOR URBAN AND RURAL HOSPITALS.—

(1) **IN GENERAL.**—Section 1886(d)(3)(B) of such Act is amended—

(A) by inserting “for hospitals located in an urban area and for hospitals located in a rural area” after “subparagraph (A)”, and

(B) by inserting before the period the following: “for hospitals located in such respective area”.

42 USC 1395ww
note.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to discharges occurring on or after October 1, 1986.

42 USC 1395ww
note.

(3) **MAINTAINING CURRENT OUTLIER POLICY IN FISCAL YEAR 1987.**—For payments made under section 1886(d) of the Social Security Act for discharges occurring in fiscal year 1987—

(A) the proportions under paragraph (3)(B) for hospitals located in urban and rural areas shall be established at such levels as produce the same total dollar reduction under such paragraph as if this section had not been enacted; and

(B) the thresholds and standards used for making additional payments under paragraph (5) of such section shall be the same as those in effect as of October 1, 1986.

(c) **COMPUTING URBAN AND RURAL AVERAGES.**—Section 1886(d)(3)(A) of such Act is amended by adding at the end the following: “With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).”.

42 USC 1395ww.

(d) **REGIONAL REFERRAL CENTERS.**—

(1) **CRITERIA.**—

(A) **IN GENERAL.**—Section 1886(d)(5)(C)(i) of such Act is amended—

(i) by inserting “(I)” after “(C)(i)”, and

(ii) by adding at the end the following new subclause:

“(II) The Secretary shall provide, under subclause (I), for the classification of a rural hospital as a regional referral center if the hospital has a case mix equal to or greater than the median case mix for hospitals (other than hospitals with approved teaching programs) located in an urban area in the same region (as defined in paragraph (2)(D)), has at least 5,000 discharges a year or, if less, the median number of discharges in urban hospitals in the region in which the hospital is located (or, in the case of a rural osteopathic hospital, meets the criterion established by the Secretary under subclause (I) with respect to the annual number of discharges for such hospitals), and meets any other criteria established by the Secretary under subclause (I).”.

(B) **EFFECTIVE DATE.**—(i) Subject to clause (ii), the amendments made by subparagraph (A) shall apply to payments for discharges occurring on or after October 1, 1986.

42 USC 1395ww
note.

(ii) An appeal for classification of a rural hospital as a regional referral center, pursuant to the amendments made by subparagraph (A), which is filed before January 1, 1987, and which is approved shall be effective with respect to discharges occurring on or after October 1, 1986.

(2) **EXTENSION OF REGIONAL REFERRAL CENTER CLASSIFICATION.**—Any hospital that is classified as a regional referral center under section 1886(d)(5)(C)(i) of the Social Security Act on the date of the enactment of this Act shall continue to be classified as a regional referral center for cost reporting periods beginning on or after October 1, 1986, and before October 1, 1989.

42 USC 1395ww
note.

(3) **BUDGET-NEUTRAL IMPLEMENTATION.**—Paragraph (2) and the amendment made by paragraph (1)(A) shall be implemented in a manner that ensures that total payments under section 1886 of the Social Security Act are not increased or decreased by

42 USC 1395ww
note.

reason of the classifications required by such paragraph or amendment.

Minnesota.

(4) RURAL SECONDARY SPECIALTY DEMONSTRATION PROJECT.—

(A) ESTABLISHMENT.—The Secretary of Health and Human Services (in this paragraph referred to as the “Secretary”) shall enter into an agreement with Lake Region Hospital and Nursing Home at Fergus Falls, Minnesota, for the purpose of conducting a rural secondary specialty center demonstration project (in this paragraph referred to as the “project”) under title XVIII of the Social Security Act.

42 USC 1395.

(B) PURPOSE.—The purpose of this project shall be to determine the effect that a modified system of making payments under part A of such title to rural secondary specialty centers would have on—

42 USC 1395c.

(i) total expenditures under such part, and

(ii) the access of medicare beneficiaries located in rural areas to quality health care.

(C) PAYMENTS.—During the period of the demonstration project, payments under part A of such title shall be made under the project on the basis of average standardized amounts computed for urban areas in the region in which the project is conducted, as adjusted by a rural wage index.

(D) DURATION.—The project shall be of a maximum duration of three years.

(E) REPORTS.—The Secretary shall submit a final report to the Congress on the project not later than six months after the completion of the project.

(e) MISCELLANEOUS PROVISIONS.—

42 USC 1395ww.

(1) ANNUAL ADJUSTMENT.—Section 1886(d)(4)(C) of such Act is amended by striking “in fiscal year 1986 and at least every four fiscal years” and inserting “in fiscal year 1988 and at least annually”.

Puerto Rico.

(2) CLARIFYING AUTHORITY TO VARY RATES.—Section 1886(e)(4) of such Act is amended by adding at the end the following new sentence: “The percentage change shall be the same for all subsection (d) hospitals and subsection (d) Puerto Rico hospitals, but may be different from that for other hospitals (and units not included as such hospitals) and may vary among such other hospitals and units.”.

(3) NOTICE OF EARLIER PROMULGATION OF PERCENTAGE INCREASE.—Section 1886(e)(3) of such Act is amended—

Reports.

(A) by inserting “(A)” after “(3)”, and

(B) by adding at the end the following new subparagraph:

“(B) The Secretary, not later than April 1, 1987, for fiscal year 1988 and not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1989), shall report to the Congress the Secretary’s initial estimate of the percentage change that the Secretary will recommend or determine under paragraph (4) with respect to that fiscal year.”.

(4) EXTENSION OF SOLE COMMUNITY PROVIDER PROVISION.—Section 1886(d)(5)(C)(ii) of such Act is amended by striking “1986” and inserting “1988”.

42 USC 1395ww
note.

(f) PROMULGATION OF NEW RATE.—The Secretary of Health and Human Services shall provide, within 30 days after the date of the enactment of this Act, for the publication of the payments rates that will apply under section 1886 of the Social Security Act, for dis-

charges occurring on or after October 1, 1986, taking into account the amendments made by this section, without regard to the provisions of chapter 5 of title 5, United States Code.

5 USC 500 *et seq.*

SEC. 9303. PAYMENTS FOR HOSPITAL CAPITAL-RELATED COSTS.

(a) **IN GENERAL.**—Section 1886(g) of the Social Security Act (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

“(3)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of inpatient hospital services of a subsection (d) hospital, the Secretary shall reduce the amounts of such payments otherwise established under this title by—

“(i) 3.5 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1987,

“(ii) 7 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1988, and

“(iii) 10 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) occurring during fiscal year 1989.

“(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(C)(ii)).

“(C) If the Secretary provides, under subsection (a)(4), for the inclusion of other capital-related costs in operating costs of inpatient hospital services, the Secretary shall provide—

“(i) notwithstanding any other provision of this title, for the continuation of payment under the reasonable cost methodology described in section 1861(v)(1) with respect to capital-related costs of any hospital that is such a sole community hospital for cost reporting periods beginning before October 1, 1990, and

42 USC 1395x.

“(ii) in the design of such payment system that the aggregate payment amounts under this title for such other capital-related costs for payments attributable to portions of cost reporting periods occurring during fiscal year 1988 and fiscal year 1989 shall approximate the aggregate payment amount under this title that would have been made (taking into account the provisions of subparagraphs (A) and (B)) during that fiscal year but for the inclusion of such costs by the Secretary.”

(b) **ADDITION OF PUERTO RICO HOSPITALS.**—Effective for cost reporting periods beginning and discharges occurring (as the case may be) on or after October 1, 1987, section 1886(g)(3)(A) of the Social Security Act (as amended by subsection (a)) is amended by inserting “and a subsection (d) Puerto Rico hospital” after “subsection (d) hospital”.

(c) **CLARIFICATION OF SECRETARIAL AUTHORITY TO INCORPORATE PAYMENT FOR OTHER CAPITAL-RELATED COSTS UNDER THE PROSPECTIVE PAYMENT SYSTEM.**—Section 1886(a)(4) of such Act is amended by striking “October 1, 1987” and inserting “October 1 of 1987 (or of such later year as the Secretary may, in his discretion, select)”.

Ante, p. 749.

SEC. 9304. COVERAGE OF HOSPITALS IN PUERTO RICO UNDER A DRG PROSPECTIVE PAYMENT SYSTEM.

(a) **IN GENERAL.**—Section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

42 USC 1395f.

42 USC 1395e.

“(9)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services of a subsection (d) Puerto Rico hospital for inpatient hospital discharges in a fiscal year beginning on or after October 1, 1987, is equal to the sum of—

“(i) 75 percent of the Puerto Rico adjusted DRG prospective payment rate (determined under subparagraph (B) or (C)) for such discharges, and

“(ii) 25 percent of the discharge-weighted average of—

“(I) the national adjusted DRG prospective payment rate (determined under paragraph (3)(D)) for hospitals located in an urban area, and

Rural areas.

“(II) such rate for hospitals located in a rural area, for such discharges, adjusted in the manner provided in paragraph (3)(E) for different area wage levels. As used in this section, the term ‘subsection (d) Puerto Rico hospital’ means a hospital that is located in Puerto Rico and that would be a subsection (d) hospital (as defined in paragraph (1)(B)) if it were located in one of the fifty States.

Rural areas.

Urban areas.

“(B) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge in fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for such hospitals located in urban or rural areas within Puerto Rico, as follows:

“(i) The Secretary shall determine the target amount (as defined in subsection (b)(3)(A)) for the hospital for the cost reporting period beginning in fiscal year 1987 and increase such amount by prorating the applicable percentage increase (as defined in subsection (b)(3)(B)) to update the amount to the midpoint in fiscal year 1988.

“(ii) The Secretary shall standardize the amount determined under clause (i) for each hospital by—

“(I) excluding an estimate of indirect medical education costs,

“(II) adjusting for variations among hospitals by area in the average hospital wage level,

“(III) adjusting for variations in case mix among hospitals, and

“(IV) excluding an estimate of the additional payments to certain subsection (d) Puerto Rico hospitals to be made under subparagraph (D)(v) (relating to disproportionate share payments).

“(iii) The Secretary shall compute a discharge weighted average of the standardized amounts determined under clause (ii) for all hospitals located in an urban area and for all hospitals located in a rural area (as such terms are defined in paragraph (2)(D)).

“(iv) The Secretary shall reduce the average standardized amount by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

“(v) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respec-

tively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

“(I) the average standardized amount (computed under clause (iii) and reduced under clause (iv)) for hospitals located in an urban or rural area, respectively, and

“(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

“(vi) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals’ costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (v) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rican average hospital wage level.

“(C) The Secretary shall determine a Puerto Rico adjusted DRG prospective payment rate, for each inpatient hospital discharge after fiscal year 1988 involving inpatient hospital services of a subsection (d) Puerto Rico hospital for which payment may be made under part A of this title. Such rate shall be determined for hospitals located in urban or rural areas within Puerto Rico as follows:

Urban areas.
Rural areas.

42 USC 1395c.

“(i) The Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area equal to the respective average standardized amount computed for the previous fiscal year under subparagraph (B)(iii) or under this clause, increased for fiscal year 1989 by the applicable percentage increase under subsection (b)(3)(B), and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4), and adjusted to reflect the most recent case-mix data available.

“(ii) The Secretary shall reduce each of the average standardized amounts by a proportion equal to the proportion (estimated by the Secretary) of the amount of payments under this paragraph which are additional payments described in subparagraph (D)(i) (relating to outlier payments).

“(iii) For each discharge classified within a diagnosis-related group for hospitals located in an urban or rural area, respectively, the Secretary shall establish a Puerto Rico DRG prospective payment rate equal to the product of—

“(I) the average standardized amount (computed under clause (i) and reduced under clause (ii)) for hospitals located in an urban or rural area, respectively, and

“(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

“(iv) The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of hospitals’ costs which are attributable to wages and wage-related costs, of the Puerto Rico DRG prospective payment rate computed under clause (iii) for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the Puerto Rico average hospital wage level.

“(D) The following provisions of paragraph (5) shall apply to subsection (d) Puerto Rico hospitals receiving payment under this paragraph in the same manner and to the extent as they apply to subsection (d) hospitals receiving payment under this subsection:

“(i) Subparagraph (A) (relating to outlier payments).

“(ii) Subparagraph (B) (relating to payments for indirect medical education costs), except that for this purpose the sum of the amount determined under subparagraph (A) of this paragraph and the amount paid to the hospital under clause (i) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(B)(i)(I).

“(iii) Subparagraph (C)(iii) (relating to exceptions and adjustments).

“(iv) Subparagraph (E) (relating to payments for costs of certified registered nurse anesthetists).

“(v) Subparagraph (F) (relating to disproportionate share payments), except that for this purpose the sum described in clause (ii) of this subparagraph shall be substituted for the sum referred to in paragraph (5)(F)(ii)(I).”

42 USC 1395ww.

(b) **CONFORMING AMENDMENTS.**—(1) The first sentence of subclause (I) of section 1886(d)(5)(C)(i)(I) of such Act, as redesignated by section 9302(d), is amended by inserting “(other than under paragraph (9))” after “established under this subsection”.

(2) The second and third sentences of section 1886(d)(5)(C)(ii) of such Act are each amended by inserting “(other than under paragraph (9))” after “payment amounts under this subsection”.

(c) **BUDGET NEUTRALITY.**—Section 1886(e)(1) of the Social Security Act is amended by adding at the end the following new subparagraph:

“(C) For discharges occurring in fiscal year 1988, the Secretary shall provide for such equal proportional adjustment in each of the average standardized amounts otherwise computed under subsection (d)(3) for that fiscal year as may be necessary to assure that—

“(i) the aggregate payment amounts otherwise provided under subsections (d)(1)(A)(iii), (d)(5), and (d)(9) for that fiscal year for operating costs of inpatient hospital services of subsection (d) hospitals and subsection (d) Puerto Rico hospitals,

are not greater or less than—

“(ii) the payment amounts that would have been payable for such services for those same hospitals for that fiscal year but for the enactment of the amendments made by section 9304 of the Omnibus Budget Reconciliation Act of 1986.”

42 USC 1395ww
note.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall apply to discharges occurring on or after October 1, 1987.

SEC. 9305. IMPROVING QUALITY OF CARE WITH RESPECT TO PART A SERVICES.

(a) **REFINEMENT OF PROSPECTIVE PAYMENT SYSTEM.**—

(1) **DEVELOPMENT OF LEGISLATIVE PROPOSAL.**—The Secretary of Health and Human Services shall develop and submit to Congress a specific legislative proposal to improve the classification and payment system under section 1886(d) of the Social Security Act (and, as appropriate, the system for payment of outliers under section 1886(d)(5)(A) of such Act) in order to assure that the amount of payment per discharge approximates the cost of medically necessary care provided in an efficient manner for individual patients or classes of patients with similar conditions.

Ante, p. 1985.

(2) **ACCOUNTING FOR SEVERITY OF ILLNESS.**—In developing the proposal, the Secretary shall account for variations in severity

of illness and case complexity which are not adequately accounted for by the current classification and payment system.

(3) DEADLINE.—The proposal shall be submitted to Congress by not later than 2 years after the date of the enactment of this Act.

(b) REQUIRING NOTICE OF HOSPITAL DISCHARGE RIGHTS.—

(1) REQUIREMENT FOR HOSPITALS TO PROVIDE STATEMENT.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)), as amended by section 1895(b) of the Tax Reform Act of 1986 and by section 233 of the Veterans' Benefits Improvement and Health-Care Authorization Act of 1986, is amended—

Post, p. 2025.

Post, p. 2931.

(A) by striking “and” at the end of the subparagraph (K),

(B) by striking the period at the end of subparagraph (L) and inserting “, and”, and

(C) by inserting after subparagraph (L) the following new subparagraph:

“(M) in the case of hospitals, to provide to each individual who is entitled to benefits under part A (or to a person acting on the individual's behalf), at or about the time of the individual's admission as an inpatient to the hospital, a written statement (containing such language as the Secretary prescribes consistent with this paragraph) which explains—

“(i) the individual's rights to benefits for inpatient hospital services and for post-hospital services under this title,

“(ii) the circumstances under which such an individual will and will not be liable for charges for continued stay in the hospital,

“(iii) the individual's right to appeal denials of benefits for continued inpatient hospital services, including the practical steps to initiate such an appeal, and

“(iv) the individual's liability for payment for services if such a denial of benefits is upheld on appeal, and which provides such additional information as the Secretary may specify.”

(2) EFFECTIVE DATE.—The Secretary of Health and Human Services shall first prescribe the language required under section 1866(a)(1)(M) of the Social Security Act not later than six months after the date of the enactment of this Act. The requirement of such section shall apply to admissions to hospitals occurring on such date (not later than 60 days after the date such language is first prescribed) as the Secretary shall provide.

42 USC 1395cc
note.

(c) REQUIRING HOSPITALS TO PROVIDE DISCHARGE PLANNING PROCESS.—

(1) REQUIREMENT AS CONDITION OF PARTICIPATION.—Section 1861(e)(6) of the Social Security Act (42 U.S.C. 1395x(e)(6)) is amended—

(A) by inserting “(A)” after “(6)”, and

(B) by inserting before the semicolon at the end the following: “and (B) has in place a discharge planning process that meets the requirements of subsection (ee)”.

(2) DISCHARGE PLANNING PROCESS DEFINED.—Section 1861 of such Act is further amended by adding at the end the following new subsection:

"DISCHARGE PLANNING PROCESS

"(ee)(1) A discharge planning process of a hospital shall be considered sufficient if it is applicable to services furnished by the hospital to individuals entitled to benefits under this title and if it meets the guidelines and standards established by the Secretary under paragraph (2).

"(2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:

"(A) The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

"(B) Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient's representative, or patient's physician.

"(C) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

"(D) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services and the availability of those services.

"(E) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

"(F) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

"(G) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel."

(3) EFFECT OF ACCREDITATION.—The second sentence of section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended—

(A) by inserting "requires a discharge planning process (or imposes another requirement which serves substantially the same purpose)," after "the same purpose)", and

(B) by inserting "clause (A) or (B) of" after "comply also with".

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to hospitals as of one year after the date of the enactment of this Act.

(d) REVIEW OF STANDARDS FOR MEDICARE CONDITIONS OF PARTICIPATION FOR ASSURING QUALITY OF INPATIENT HOSPITAL SERVICES.—The Secretary of Health and Human Services shall arrange for a study of the adequacy of the standards used for hospitals, for purposes of meeting the conditions of participation under title XVIII of the Social Security Act, in assuring the quality of services furnished in hospitals. The Secretary shall report to Congress on the results of the study by not later than 2 years after the date of the enactment of this Act.

42 USC 1395x
note.

42 USC 1395.
Reports.

(e) STUDY OF PAYMENT FOR ADMINISTRATIVELY NECESSARY DAYS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study to determine whether a payment should be made (in a budget-neutral manner under title XVIII of such Act to hospitals receiving payments under section 1886(d) of such Act) to a hospital for administratively necessary days, separate from the per-discharge and outlier payments made under such section.

Hospitals.

42 USC 1395.

(2) ADMINISTRATIVELY NECESSARY DAYS DEFINED.—In this subsection, an “administratively necessary day” is a day of continued inpatient hospital stay, for an individual entitled to benefits under part A of title XVIII of the Social Security Act, necessitated by a delay in obtaining placement for the individual in a skilled nursing facility.

42 USC 1935c.

(3) CONSIDERATIONS IN CONDUCTING STUDY.—In conducting the study, the Secretary shall consider—

(A) the need for such a payment in order to minimize—

(i) the disproportionate financial impact of current law on certain hospitals (or hospitals in certain locations) due to difficulties in arranging for appropriate post-hospital care, such as difficulties resulting from a shortage of beds in skilled nursing facilities where those hospitals are located and from the source of payment for such care, and

(ii) the risk of inappropriate discharge to a non-institutional or inappropriate institutional setting of individuals who need post-hospital services in a skilled nursing facility, and

(B) the administrative mechanisms that can be used to prevent inappropriate payments for administratively necessary days.

(4) REPORT ON STUDY.—The Secretary shall report to Congress on the results of the study not later than January 1, 1989.

(f) EXTENDING WAIVER OF LIABILITY PROVISIONS TO HOSPICE PROGRAMS.—

42 USC 1395y note.

(1) IN GENERAL.—The Secretary of Health and Human Services shall, for purposes of determining whether payments to a hospice program should be denied pursuant to section 1862(a)(1)(C) of the Social Security Act, apply (under section 1879(a) of such Act) a presumption of compliance of 2.5 percent (based on the number of days of hospice care billed) in a manner substantially similar to that provided to home health agencies under policies in effect as of July 1, 1985.

42 USC 1395y.
Infra.

(2) EFFECTIVE DATE.—Paragraph (1) shall apply to hospice care furnished on or after the first day of the first month that begins at least 6 months after the date of the enactment of this Act and before November 1, 1988.

(g) EXTENSION OF WAIVER OF LIABILITY PROVISIONS TO CERTAIN COVERAGE DENIALS FOR HOME HEALTH SERVICES.—

(1) IN GENERAL.—Section 1879 of the Social Security Act (42 U.S.C. 1395pp) is amended—

(A) in subsection (a)(1), by inserting “or by reason of a coverage denial described in subsection (g)” after “section 1862(a)(1) or (9)”;

(B) in the first sentence of subsection (a), by inserting “and as though the coverage denial described in subsection (g) had not occurred” before the period at the end;

42 USC 1395y.

(C) in the third sentence of subsection (a), by inserting “or by reason of a coverage denial described in subsection (g)” after “section 1862(a)(1) or (9)”;

(D) in subsection (c), by inserting “or by reason of a coverage denial described in subsection (g)” after “section 1862(a)(1) or (9)”; and

(E) by adding at the end the following new subsections:

“(f)(1) A home health agency which meets the applicable requirements of paragraphs (3) and (4) shall be presumed to meet the requirement of subsection (a)(2) with respect to any coverage denial described in subsection (g).

“(2) The presumption of paragraph (1) with respect to specific services may be rebutted by actual or imputed knowledge of the facts described in subsection (a)(2), including any of the following:

“(A) Notice by the fiscal intermediary of the fact that payment may not be made under this title with respect to the services.

“(B) It is clear and obvious that the provider should have known at the time the services were furnished that they were excluded from coverage.

“(3) The requirements of this paragraph are as follows:

“(A) The agency complies with requirements of the Secretary under this title respecting timely submittal of bills for payment and medical documentation.

“(B) The agency program has reasonable procedures to notify promptly each patient (and the patient’s physician) where it is determined that a patient is being or will be furnished items or services which are excluded from coverage under this title.

“(4) The requirement of this paragraph is that, on the basis of bills submitted by a home health agency during the previous quarter, the rate of denial of bills for the agency by reason of a coverage denial described in subsection (g) does not exceed 2.5 percent, computed based on visits for home health services billed.

“(5) In this subsection, the term ‘fiscal intermediary’ means, with respect to a home health agency, an agency or organization with an agreement under section 1816 with respect to the agency.

“(g) The coverage denial described in this subsection is, with respect to the provision of home health services to an individual, a failure to meet the requirements of section 1814(a)(2)(C) or section 1835(a)(2)(A) in that the individual—

“(1) is or was not confined to his home, or

“(2) does or did not need skilled nursing care on an intermittent basis.”

42 USC 1395pp
note.

(2) **REPORTS.**—The Secretary of Health and Human Services shall report to Congress annually in March of 1987 and 1988—

42 USC 1395.

(A) information on the frequency and distribution (by type of provider) of denials of bills for payment under title XVIII of the Social Security Act for extended care services, home health services, and hospice care, by reason of section 1862(a)(1) or (9) of such Act and coverage denials described in section 1879(g) of such Act, including—

(i) the reasons for such denials,

(ii) the extent to which payments were nonetheless made because of section 1879 of such Act, and

(iii) the rate of reversals of such denials, and

(B) such other information as may be appropriate to evaluate the appropriateness of any percentage standards

Ante, p. 1991.

established for the granting of favorable presumptions with respect to such denials.

(3) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to coverage denials occurring on or after July 1, 1987, and before October 1, 1989. 42 USC 1395pp note.

(h) **DEVELOPMENT OF UNIFORM NEEDS ASSESSMENT INSTRUMENT.**— 42 USC 1395x note.

(1) **DEVELOPMENT.**—The Secretary of Health and Human Services shall develop a uniform needs assessment instrument that—

(A) evaluates—

- (i) the functional capacity of an individual,
- (ii) the nursing and other care requirements of the individual to meet health care needs and to assist with functional incapacities, and
- (iii) the social and familial resources available to the individual to meet those requirements; and

(B) can be used by discharge planners, hospitals, nursing facilities, other health care providers, and fiscal intermediaries in evaluating an individual's need for post-hospital extended care services, home health services, and long-term care services of a health-related or supportive nature.

The Secretary may develop more than one such instrument for use in different situations.

(2) **ADVISORY PANEL.**—The Secretary shall develop any instrument in consultation with an advisory panel, appointed by the Secretary, that includes experts in the delivery of post-hospital extended care services, home health services, and long-term care services and includes representatives of hospitals, of physicians, of skilled nursing facilities, of home health agencies, of long-term care providers, of fiscal intermediaries, and of medicare beneficiaries.

(3) **REPORT ON INSTRUMENT.**—The Secretary shall report to Congress, not later than January 1, 1989, on the instrument or instruments developed under this section. The report shall recommendations for the appropriate use of such instrument or instruments.

(i) **INCLUDING IN ANNUAL REPORTS ON PROSPECTIVE PAYMENT SYSTEM INFORMATION ON QUALITY OF POST-HOSPITAL CARE.**—

(1) **IN GENERAL.**—Section 603(a)(2) of the Social Security Amendments of 1983 is amended—

(A) by striking “1987” in subparagraph (A) and inserting “1989”, and

42 USC 1395ww note.

(B) by adding at the end the following new subparagraph:
“(E) In each annual report to Congress under subparagraph (A), the Secretary shall include—

“(i) an evaluation of the adequacy of the procedures for assuring quality of post-hospital services furnished under title XVIII of the Social Security Act,

42 USC 1395.

“(ii) an assessment of problems that have prevented groups of medicare beneficiaries (including those eligible for medical assistance under title XIX of such Act) from receiving appropriate post-hospital services covered under such title, and

42 USC 1396.

“(iii) information on reconsiderations and appeals taken under title XVIII of such Act with respect to payment for post-hospital services.”.

42 USC 1395ww
note.
42 USC 1395x
note.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1)(B) shall apply to reports for years beginning with 1986.
(k) **PRIOR AND CONCURRENT AUTHORIZATION DEMONSTRATION PROJECT.**—

Hospitals.

(1) **IN GENERAL.**—The Secretary of Health and Human Services shall conduct a demonstration program concerning prior and concurrent authorization for post-hospital extended care services and home health services furnished under part A or part B of title XVIII of the Social Security Act.

42 USC 1395c,
1395j.

(2) **SCOPE.**—The program shall include at least four projects and shall be initiated by not later than January 1, 1987.

Hospitals.
Physicians.

(3) **CONSULTATION AND MONITORING.**—The program shall be developed in consultation with an advisory panel that includes experts in the delivery of post-hospital extended care services, home health services, and long-term care services and includes representatives of hospitals, of physicians, of skilled nursing facilities, of home health agencies, of long-term care providers, of fiscal intermediaries, and of medicare beneficiaries. The Secretary shall monitor the acceptance of individuals entitled to benefits under title XVIII of the Social Security Act by providers to ensure that the placement of such individuals is not delayed until the results of prior and concurrent review are known.

42 USC 1395.

(4) **EVALUATION AND REPORT.**—The Secretary shall evaluate the demonstration program conducted under this subsection and shall report to Congress on such evaluation no later than February 1, 1989. Such evaluation and report shall address—

(A) the administrative and program costs for prior and concurrent authorization across demonstration projects and in comparison to administrative and program costs under the current system of retroactive review, including costs for uncovered services paid under the waiver of liability which would not be incurred under prior or concurrent authorization;

(B) impact of prior or concurrent authorization on access to and availability of extended care services and home health services in comparison to the current system (including costs to providers) and on timely discharge of hospital inpatients; and

(C) accuracy and associated cost savings of payment determinations and rates of claim reversals under prior or concurrent authorization versus the current system.

Grants.
Contracts.
42 USC 1395i.

(5) **FUNDING.**—Expenditures made for the demonstration program shall be made from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act. Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this subsection.

42 USC 1395.

(6) **WAIVER OF MEDICARE REQUIREMENTS.**—The Secretary shall waive compliance with such requirements of title XVIII of the Social Security Act to the extent and for the period the Secretary finds necessary for the conduct of the demonstration program.

SEC. 9306. PAYMENTS TO LARGE RURAL HOSPITALS SERVING A DISPROPORTIONATE SHARE OF LOW-INCOME PATIENTS.

(a) **QUALIFYING HOSPITALS.**—Section 1886(d)(5)(F)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(v)) is amended by adding at the end the following new sentence:

“A hospital located in a rural area and with 500 or more beds also ‘serves a significantly disproportionate number of low income patients’ for a cost reporting period if the hospital has a disproportionate patient percentage (as defined in clause (vi)) for that period which equals or exceeds a percentage specified by the Secretary.”.

(b) **PAYMENT AMOUNT.**—Section 1886(d)(5)(F)(iv) of such Act is amended—

(1) in subclause (I), by inserting “or is described in the second sentence of subclause (III)” after “100 or more beds”, and

(2) in subclause (III), by inserting “and is not described in the second sentence of clause (v)” after “rural area”.

(c) **EXTENSION OF DISPROPORTIONATE SHARE PROVISION.**—Section 1886(d) of such Act is further amended, in paragraphs (2)(C)(iv), (3)(C)(ii), (5)(B)(ii), and (5)(F)(i), by striking “1988” each place it appears and inserting “1989”.

(d) **EFFECTIVE DATE.**—The amendments made by subsections (a) and (b) shall apply to discharges occurring on or after October 1, 1986.

42 USC 1395ww
note.

SEC. 9307. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PART A.

(a) **TEMPORARY WAIVER OF INPATIENT LIMITATIONS FOR THE CONNECTICUT HOSPICE, INC.**—With respect to the Connecticut Hospice, Inc., for hospice care provided before October 1, 1988, the reference in section 1861(dd)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1395x(dd)(2)(A)(iii)) to “20 percent” is deemed a reference to “50 percent”.

(b) **MASSACHUSETTS MEDICARE REPAYMENT.**—The Secretary of Health and Human Services shall not, on or after the date of the enactment of this section and before January 1, 1988, recoup from, or otherwise reduce payments to, hospitals in the State of Massachusetts because of alleged overpayments to such hospitals under part A of title XVIII of the Social Security Act which occurred during the period of the State-wide hospital reimbursement demonstration project conducted in that State, between October 1, 1982, and June 30, 1986, under section 402 of the Social Security Amendments of 1967 and section 222 of the Social Security Amendments of 1972.

42 USC 1395c.

(c) **PART A COBRA TECHNICAL CORRECTIONS.**—(1) Effective as if included in the enactment of the Tax Reform Act of 1986, if House Concurrent Resolution 395 (99th Congress, 2d Session) has not been adopted, section 1895(b) of the Tax Reform Act of 1986 is amended—

42 USC 1395b-1,
1395ll,
86 Stat. 1390.
42 USC 1395ww.

(A) by striking paragraph (1), and

(B) by striking subparagraphs (A) and (B) of paragraph (2).

(2) Effective as if included in the enactment of the Tax Reform Act of 1986—

Post, p. 2095.

(A) section 1895(b) of such Act is amended, in subparagraph (A)(ii) of the paragraph relating to “PHYSICIAN PAYMENT”, by inserting before the period the following: “the first place it appears”, and

(B) section 1895(d)(5)(A) of such Act is amended by striking “162(k)(2)” and inserting “162(k)(5)”.

42 USC 162.

42 USC 1395ww. (3) If House Concurrent Resolution 395 (99th Congress, 2d Session) has been adopted, effective for discharges occurring on or after May 1, 1986, section 1886(d)(5)(F)(vi)(I) of the Social Security Act is amended—

(A) by striking “supplementary” and inserting “supplemental”, and

(B) by striking “fiscal year” and inserting “period”.

42 USC 1395dd.

Ante, p. 164.

Effective date.

42 USC 1395ww

note.

42 USC 1395ww

note.

(4) Paragraphs (2) and (3) of section 1867(b) of the Social Security Act are amended by striking “legally responsible”.

(d) MISCELLANEOUS ACCOUNTING PROVISION.—Effective on the date of the enactment of Public Law 99-107, in applying section 5(a) of such Act, a cost reporting period beginning on September 28, 29, or 30 is deemed to begin on October 1 and any reference to September 30 is deemed also to be a reference to September 27.

PART 2—PROVISIONS RELATING TO PARTS A AND B

SEC. 9311. PERIODIC INTERIM PAYMENT SYSTEM (PIP) FOR DRG HOSPITALS AND PROMPT PAYMENT FOR MEDICARE PROVIDERS.

(a) PERIODIC INTERIM PAYMENTS.—

(1) IN GENERAL.—Section 1815 of the Social Security Act (42 U.S.C. 1395g) is amended by adding at the end the following new subsection:

Puerto Rico.

42 USC 1395ww.

“(e)(1) The Secretary shall provide payment under this part for inpatient hospital services furnished by a subsection (d) hospital (as defined in section 1886(d)(1)(B), and including a distinct psychiatric or rehabilitation unit of such a hospital) and a subsection (d) Puerto Rico hospital (as defined in section 1886(d)(9)(A)) on a periodic interim payment basis (rather than on the basis of bills actually submitted) in the following cases:

“(A) Upon the request of a hospital which is paid through an agency or organization with an agreement with the Secretary under section 1816, if the agency or organization, for three consecutive calendar months, fails to meet the requirements of subsection (c)(2) of such section and if the hospital meets the requirements (in effect as of October 1, 1986) applicable to payment on such a basis, until such time as the agency or organization meets such requirements for three consecutive calendar months.

42 USC 1395h.

“(B) In the case of hospital that—

“(i) has a disproportionate share adjustment percentage (as established in clause (iv) of such section) of at least 5.1 percent (as computed for purposes of establishing the average standardized amounts for discharges occurring during fiscal year 1987), and

“(ii) requests payment on such basis,
but only if the hospital was being paid for inpatient hospital services on such a periodic interim payment basis as of June 30, 1987, and continues to meet the requirements (in effect as of October 1, 1986) applicable to payment on such a basis.

“(C) In the case of a hospital that—

“(i) is located in a rural area,

“(ii) has 100 or fewer beds, and

“(iii) requests payment on such basis,

Rural areas.

but only if the hospital was being paid for inpatient hospital services on such a periodic interim payment basis as of June 30, 1987, and continues to meet the requirements (in effect as of October 1, 1986) applicable to payment on such a basis.

“(2) The Secretary shall provide (or continue to provide) for payment on a periodic interim payment basis (under the standards established under section 405.454(j) of title 42, Code of Federal Regulations, as in effect on October 1, 1986) with respect to—

“(A) inpatient hospital services of a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B));

“(B) a hospital which is receiving payment under a State hospital reimbursement system under section 1814(b)(3) or 1886(c), if payment on a periodic interim payment basis is an integral part of such reimbursement system;

“(C) extended care services;

“(D) home health services; and

“(E) hospice care;

if the provider of such services elects to receive, and qualifies for, such payments.

“(3) In the case of a subsection (d) hospital or a subsection (d) Puerto Rico hospital (as defined for purposes of section 1886) which has significant cash flow problems resulting from operations of its intermediary or from unusual circumstances of the hospital's operation, the Secretary may make available appropriate accelerated payments.”

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to claims received on or after July 1, 1987.

(3) **TRANSITION.**—Upon the request of a hospital which—

(A) as of June 30, 1987, is receiving payments under part A of title XVIII of such Act for inpatient hospital services on a periodic interim payment basis,

(B) requests continuation of payment on such basis, and

(C) is paid through an agency or organization with an agreement under section 1816 of such Act,

the Secretary of Health and Human Services shall continue payment on such a basis until not earlier than the end of the first period of three consecutive calendar months (beginning no earlier than April 1987) during all of which the agency or organization has met the requirements of section 1816(c)(2) of such Act (relating to prompt payment of claims).

(b) **PROMPT PAYMENT OF CLAIMS UNDER PART A.**—Section 1816(c) of the Social Security Act (42 U.S.C. 1395h(c)) is amended—

(1) by inserting “(1)” after “(c)”, and

(2) by adding at the end the following new paragraph:

“(2)(A) Each agreement under this section shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to not less than 95 percent of all claims submitted under this title—

“(i) which are clean claims, and

“(ii) for which payment is not made on a periodic interim payment basis,

within the applicable number of calendar days after the date on which the claim is received.

“(B) In this paragraph:

“(i) The term ‘clean claim’ means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special

42 USC 1395ww.

State and local

governments.

42 USC 1395f.

Puerto Rico.

Claims.

42 USC 1395g

note.

42 USC 1395g

note.

42 USC 1395c.

Claims.

42 USC 1395h.

Claims.

treatment that prevents timely payment from being made on the claim under this title.

“(ii) The term ‘applicable number of calendar days’ means—

“(I) with respect to claims received in the 12-month period beginning October 1, 1986, 30 calendar days,

“(II) with respect to claims received in the 12-month period beginning October 1, 1987, 26 calendar days,

“(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days, and

“(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period, 24 calendar days.

Claims.

“(C) If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in clause (ii) of subparagraph (B)) after a clean claim (as defined in clause (i) of such subparagraph) is received from a hospital, skilled nursing facility, home health agency, or hospice program that is not receiving payments on a periodic interim payment basis with respect to such services, interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made.”

(c) PROMPT PAYMENT OF CLAIMS UNDER PART B.—Section 1842(c) of the Social Security Act (42 U.S.C. 1395u(c)) is amended—

(1) by inserting “(1)” after “(c)”, and

(2) by adding at the end the following new paragraph:

Contracts.
Claims.

“(2)(A) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall provide that payment shall be issued, mailed, or otherwise transmitted with respect to not less than 95 percent of all claims submitted under this part—

“(i) which are clean claims, and

“(ii) for which payment is not made on a periodic interim payment basis,
within the applicable number of calendar days after the date on which the claim is received.

“(B) In this paragraph:

“(i) The term ‘clean claim’ means a claim that has no defect or inpropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this part.

“(ii) The term ‘applicable number of calendar days’ means—

“(I) with respect to claims received in the 12-month period beginning October 1, 1986, 30 calendar days,

“(II) with respect to claims received in the 12-month period beginning October 1, 1987, 26 calendar days (or 19 calendar days with respect to claims submitted by participating physicians),

“(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days (or 18 calendar days with respect to claims submitted by participating physicians), and

“(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period, 24 calendar days (or 17

calendar days with respect to claims submitted by participating physicians).

“(C) If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days (as defined in clause (ii) of subparagraph (B)) after a clean claim (as defined in clause (i) of such subparagraph) is received, interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after the required payment date and ending on the date on which payment is made.”

(d) EFFECTIVE DATES.—

(1) Except as provided in paragraph (2), the amendments made by subsections (b) and (c) shall apply to claims received on or after November 1, 1986.

(2) Sections 1816(c)(2)(C)) and 1842(c)(2)(C) of the Social Security Act, as added by such amendments, shall apply to claims received on or after April 1, 1987.

(3) The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816 of the Social Security Act and contracts under section 1842 of such Act, and regulations, to such extent as may be necessary to implement the provisions of this Act on a timely basis.

Claims.

42 USC 1395h
note.
Claims.

Ante, pp. 1997,
1998.
Claims.

Contracts.

SEC. 9312. HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.

(a) REPEAL OF “2 FOR 1” CONVERSION REQUIREMENT FOR CERTAIN HEALTH MAINTENANCE ORGANIZATIONS.—Section 114(c)(2) of the Tax Equity and Fiscal Responsibility Act of 1982 is amended by adding at the end the following new subparagraph:

“(E) The preceding provisions of this paragraph shall not to apply to payments made for current, nonrisk medicare enrollees for months beginning with April 1987.”

(b) REQUIRING THE PROVISION OF AN EXPLANATION OF ENROLLEE RIGHTS.—

(1) IN GENERAL.—Subsection (c)(3) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended by adding at the end the following new subparagraph:

“(E) Each eligible organization shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation of the enrollee’s rights under this section, including an explanation of—

“(i) the enrollee’s rights to benefits from the organization,

“(ii) the restrictions on payments under this title for services furnished other than by or through the organization,

“(iii) out-of-area coverage provided by the organization,

“(iv) the organization’s coverage of emergency services and urgently needed care, and

“(v) appeal rights of enrollees.”

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 1987, and shall apply to enrollments effected on or after such date.

(c) RESTRICTING WAIVER OF REQUIREMENT OF 50 PERCENT NON-MEDICARE ENROLLMENT.—

(1) RESTRICTION ON NEW WAIVERS.—Paragraph (2) of subsection (f) of such section is amended by striking all that follows “only” and inserting a dash and the following:

42 USC 1395mm
note.

42 USC 1395mm
note.

42 USC 1396.
Contracts.
State and local
governments.

“(A) to the extent that more than 50 percent of the population of the area served by the organization consists of individuals who are entitled to benefits under this title or under a State plan approved under title XIX, or

“(B) in the case of an eligible organization that is owned and operated by a governmental entity, only with respect to a period of three years beginning on the date the organization first enters into a contract under this section, and only if the organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.”.

(2) SANCTIONS FOR NONCOMPLIANCE.—

(A) SUSPENSION OF ENROLLMENT OR PAYMENT FOR NEW ENROLLEES.—Such subsection is further amended by adding at the end the following new paragraph:

“(3) If the Secretary determines that an eligible organization has failed to comply with the requirements of this subsection, the Secretary may provide for the suspension of enrollment of individuals under this section or of payment to the organization under this section for individuals newly enrolled with the organization, after the date the Secretary notifies the organization of such noncompliance.”.

(B) TERMINATION OF CONTRACT.—Subsection (i)(1)(C) of such section is amended by striking “and (e)” and insert “(e), and (f)”.

(3) EFFECTIVE DATES.—

(A) NEW RESTRICTION.—The amendment made by paragraph (1) shall apply to modifications and waivers granted after the date of the enactment of this Act.

(B) SANCTIONS FOR NONCOMPLIANCE.—The amendments made by paragraph (2) shall take effect on the date of the enactment of this Act.

(C) TREATMENT OF CURRENT WAIVERS.—In the case of an eligible organization (or successor organization) that—

(i) as of the date of the enactment of this Act, has been granted, under paragraph (2) of section 1876(f) of the Social Security Act, a modification or waiver of the requirement imposed by paragraph (1) of that section, but

(ii) does not meet the requirement for such modification or waiver under the amendment made by paragraph (1) of this subsection,

the organization shall make, and continue to make, reasonable efforts to meet scheduled enrollment goals, consistent with a schedule of compliance approved by the Secretary of Health and Human Services. If the Secretary determines that the organization has complied, or made significant progress towards compliance, with such schedule of compliance, the Secretary may extend such waiver. If the Secretary determines that the organization has not complied with such schedule, the Secretary may provide for a sanction described in section 1876(f)(3) of the Social Security Act (as amended by this section) effective with respect to individuals enrolling with the organization after the date the Secretary notifies the organization of such noncompliance.

(d) REQUIRING PROMPT PAYMENT OF CLAIMS.—

42 USC 1395mm
note.

42 USC 1395mm.

(1) IN GENERAL.—Subsection (g) of such section is amended by adding at the end the following new paragraph:

“(6)(A) A risk-sharing contract under this section shall require the eligible organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to such contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

Contracts.

Ante, pp. 1997, 1998.

“(B) In the case of an eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with subparagraph (A), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this section under the contract. If the Secretary provides for such direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this section to reflect the amount of the Secretary’s payments (and costs incurred by the Secretary in making such payments).”

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to risk-sharing contracts under section 1876 of the Social Security Act with respect to services furnished on or after January 1, 1987.

Contracts.
42 USC 1395mm
note.

(e) REQUIRING ACCESS TO FINANCIAL RECORDS AND DISCLOSURE OF INTERNAL LOANS.—

(1) IN GENERAL.—Subsection (i)(3)(C) of such section is amended—

(A) by striking “and” at the end,

(B) by inserting “(i)” after “(C)”, and

(C) by adding at the end the following new clauses:

“(ii) shall require the organization to provide and supply information (described in section 1866(b)(2)(C)(ii)) in the manner such information is required to be provided or supplied under that section;

42 USC 1395cc.

“(iii) shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties; and”.

Loans.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to contracts as of January 1, 1987.

Contracts.
42 USC 1395mm
note.

(f) AUTHORITY TO IMPOSE CIVIL MONEY PENALTIES.—Subsection (i) of such section is amended by adding at the end the following new paragraph:

“(6)(A) Any eligible organization with a risk-sharing contract under this section that fails substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under such contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals, is subject to a civil money penalty of not more than \$10,000 for each such failure.

Contracts.

“(B) The provisions of section 1128A (other than subsection (a)) shall apply to a civil money penalty under subparagraph (A) in the same manner as they apply to a civil money penalty under that section.”.

Post, pp. 2003, 2008.

(g) STUDY OF AAPCC AND ACR.—The Secretary of Health and Human Services shall provide, through contract with an appropriate organization, for a study of the methods by which—

Contracts.
42 USC 1395 mm
note.

42 USC 1395mm. (1) the adjusted average per capita cost ("AAPCC", as defined in section 1876(a)(4) of the Social Security Act) can be refined to more accurately reflect the average cost of providing care to different classes of patients, and

(2) the adjusted community rate ("ACR", as defined in section 1876(e)(3) of such Act) can be refined.

The Secretary shall submit to Congress, by not later than January 1, 1988, specific legislative recommendations concerning methods by which the calculation of the AAPCC and the ACR can be refined.

42 USC 1395mm
note.

(h) ALLOWING MEDICARE BENEFICIARIES TO DISENROLL AT A LOCAL SOCIAL SECURITY OFFICE.—The Secretary of Health and Human Services shall provide that individuals enrolled with an eligible organization under section 1876 of the Social Security Act may disenroll, on and after June 1, 1987, at any local office of the Social Security Administration.

42 USC 1395mm
note.

(i) USE OF RESERVE FUNDS.—Notwithstanding any provision of section 1876(g)(5) of the Social Security Act (42 U.S.C. 1395mm(g)(5)) to the contrary, funds reserved by an eligible organization under such section before the date of the enactment of this Act may be applied, at the organization's option, to offset the amount of any reduction in payment amounts to the organization effected under Public Law 99-177 during fiscal year 1986.

99 Stat. 1037.

SEC. 9313. PROVISIONS RELATING TO IMPROVEMENT OF QUALITY OF CARE.

(a) PERMITTING PROVIDER REPRESENTATION OF BENEFICIARIES.—

42 USC 406,
1302, 1395hh.

(1) IN GENERAL.—Section 1869(b)(1) of the Social Security Act (42 U.S.C. 1395ff(b)(1)) is amended by adding at the end the following new sentence: "Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this subsection by a person that furnishes or supplies the individual, directly or indirectly, with services or items solely on the basis that the person furnishes or supplies the individual with such a service or item. Any person that furnishes services or items to an individual may not represent an individual under this subsection with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal. If a person furnishes services or items to an individual and represents the individual under this subsection, the person may not impose any financial liability on such individual in connection with such representation."

42 USC 1395pp.

(2) TREATMENT OF COSTS OF UNSUCCESSFUL APPEAL.—Section 1861(v)(1) of such Act (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

"(R) In determining such reasonable cost, costs incurred by a provider of services representing a beneficiary in an unsuccessful appeal of a determination described in section 1869(b) shall not be allowable as reasonable costs."

42 USC 1395x
note.

(3) EFFECTIVE DATE.—The amendments made by this paragraph take effect on the date of the enactment of this Act.

(b) PERMITTING REVIEW OF TECHNICAL DENIALS.—

(1) IN GENERAL.—Section 1869 of such Act is further amended—

(A) in subsection (a), by inserting before “shall” the following: “and any other determination with respect to a claim for benefits under part A”, and

(B) in subsection (b)(1)—

(i) by striking “or” at the end of subparagraph (B),

(ii) by inserting “, or” at the end of subparagraph (C),

and

(iii) by inserting after subparagraph (C) the following

new subparagraph:

“(D) any other denial (other than under part B of title XI) of a claim for benefits under part A or a claim for benefits with respect to home health services under part B,”.

42 USC 1320c.

(2) EFFECTIVE DATE.—The amendments made by this subsection take effect on the date of the enactment of this Act.

42 USC 1395ff note.

(c) PROHIBITION OF CERTAIN PHYSICIAN INCENTIVE PLANS.—

(1) MAKING CERTAIN PLANS SUBJECT TO CIVIL MONETARY PENALTIES.—Section 1128A of the Social Security Act (42 U.S.C. 1320a-7a) is amended—

Post, p. 2008.

(A) by striking “subsection (a)” each place it appears and inserting “subsection (a) or (b)”,

(B) in subsection (a)(1), by striking “(h)(1)” and “(h)(2)” and inserting “(i)(1)” and “(i)(2)”, respectively,

(C) in subsection (f), by striking “subsection (d)” and inserting “subsection (e)”,

(D) by redesignating subsections (b) through (h) as subsections (c) through (i), respectively, and

(E) by inserting after subsection (a) the following new subsection:

“(b)(1) If a hospital, an eligible organization with a risk-sharing contract under section 1876, or an entity with a contract under section 1903(m) knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to individuals who—

Contracts.
Ante, p. 1999.
42 USC 1396b.

“(A) are entitled to benefits under part A or part B of title XVII or to medical assistance under a State plan approved under title XIX,

State and local governments.
42 USC 300u.
42 USC 1396.

“(B) in the case of an eligible organization or an entity, are enrolled with the organization or entity, and

“(C) are under the direct care of the physician, the hospital or organization shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$2,000 for each such individual with respect to whom the payment is made.

“(2) Any physician who knowingly accepts receipt of a payment described in paragraph (1) shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than \$2,000 for individual described in such paragraph with respect to whom the payment is made.”

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to—

42 USC 1320a-7a note.

(A) payments by hospitals occurring more than 6 months after the date of the enactment of this Act, and

(B) payments by eligible organizations or entities occurring on or after April 1, 1989.

(3) STUDY.—The Secretary of Health and Human Services shall report to Congress, not later than January 1, 1988, concerning incentive arrangements offered by health mainte-

Reports.
Physicians.
42 USC 1320a-7a note.

nance organizations and competitive medical plans to physicians. The report shall—

(A) review the type of incentive arrangements in common use,

(B) evaluate their potential to pressure improperly physicians to reduce or limit services in a medically inappropriate manner, and

(C) make recommendations concerning providing for an exception, to the prohibition contained in section 1128A(b) of the Social Security Act, for incentive arrangements that may be used by such organizations and plans to encourage efficiency in the utilization of medical and other services but that do not have a substantial potential for adverse effect on quality.

Post, pp. 2003,
2008.

42 USC 1395//
note.

(d) STUDY TO DEVELOP A STRATEGY FOR QUALITY REVIEW AND ASSURANCE.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall arrange for a study to design a strategy for reviewing and assuring the quality of care for which payment may be made under title XVIII of the Social Security Act.

42 USC 1395.

(2) ITEMS INCLUDED IN STUDY.—Among other items, the study shall—

(A) identify the appropriate considerations which should be used in defining “quality of care”;

(B) evaluate the relative roles of structure, process, and outcome standards in assuring quality of care;

(C) develop prototype criteria and standards for defining and measuring quality of care;

(D) evaluate the adequacy and focus of the current methods for measuring, reviewing, and assuring quality of care;

(E) evaluate the current research on methodologies for measuring quality of care, and suggest areas of research needed for further progress;

(F) evaluate the adequacy and range of methods available to correct or prevent identified problems with quality of care;

(G) review mechanisms available for promoting, coordinating, and supervising at the national level quality review and assurance activities; and

(H) develop general criteria which may be used in establishing priorities in the allocation of funds and personnel in reviewing and assuring quality of care.

(3) REPORT.—The Secretary shall submit to Congress, not later than 2 years after the date of the enactment of this Act, a report on the study. Such report shall address the items described in paragraph (2) and shall include recommendations with respect to strengthening quality assurance and review activities for services furnished under the medicare program.

(4) ARRANGEMENTS FOR STUDY.—(A) The Secretary shall request the National Academy of Sciences, acting through appropriate units, to submit an application to conduct the study described in this subsection. If the Academy submits an acceptable application, the Secretary shall enter into an appropriate arrangement with the Academy for the conduct of the study. If the Academy does not submit an acceptable application to conduct the study, the Secretary may request one or more appropriate nonprofit private entities to submit an application

Research and
development.

to conduct the study and may enter into an appropriate arrangement for the conduct of the study by the entity which submits the best acceptable application.

(B) In developing plans for the conduct of the study, the Secretary shall assure that consumer and provider groups, peer review organizations, the Joint Commission on Accreditation of Hospitals, professional societies, and private purchasers of care with experience and expertise in the monitoring of the quality of care are consulted.

(5) **COORDINATION.**—The Secretary shall designate an office with responsibilities for coordinating studies, under this subsection and other authority, relating to the quality of services furnished to medicare and medicaid beneficiaries, in particular studies relating to the evaluation of the prospective payment system on the quality of health care provided to medicare beneficiaries. These responsibilities shall include assessing the feasibility and costs of alternative studies in relation to their importance, overseeing and coordinating access to needed data, and maintaining a clearinghouse for both public and private sector studies.

SEC. 9314. DIRECT COSTS OF GRADUATE MEDICAL EDUCATION.

(a) **CLARIFYING COUNTING OF TIME SPENT IN OUTPATIENT SETTINGS.**—Section 1886(h)(4) of such Act, as amended by section 1895(b) of the Tax Reform Act of 1986, is amended by adding at the end the following new subparagraph:

42 USC 1395ww.
Post, p. 2095.

“(E) **COUNTING TIME SPENT IN OUTPATIENT SETTINGS.**—Such rules shall provide that only time spent in activities relating to patient care shall be counted and that all the time so spent by a resident under an approved medical residency training program shall be counted towards the determination of full-time equivalency, without regard to the setting in which the activities are performed, if the hospital incurs all, or substantially all, of the costs for the training program in that setting.”

Hospitals.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to payments for approved residency training programs as of July 1, 1987.

42 USC 1395 ww
note.

SEC. 9315. PAYMENTS FOR HOME HEALTH SERVICES.

(a) **LIMITATIONS ON PAYMENT FOR HOME HEALTH SERVICES.**—Section 1861(v)(1)(L) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)) is amended—

(1) by inserting “(i)” after “(L)”, and

(2) by striking “the 75th percentile” and all that follows through “as the Secretary may determine.” and inserting in lieu thereof “for cost reporting periods beginning on or after—

“(I) July 1, 1985, and before July 1, 1986, 120 percent,

“(II) July 1, 1986, and before July 1, 1987, 115 percent, or

“(III) July 1, 1987, 112 percent,

of the mean of the labor-related and nonlabor per visit costs for free standing home health agencies.

“(ii) Effective for cost reporting periods beginning on or after July 1, 1986, such limitations shall be applied on an aggregate basis for the agency, rather than on a discipline specific basis, with appropriate adjustment for administrative and general costs of hospital-based agencies.”

Effective date.

42 USC 1395x
note.

(b) **CONSIDERATIONS IN ESTABLISHING LIMITS.**—In establishing limitations under section 1861(v)(1)(L) of the Social Security Act on payment for home health services for cost reporting periods beginning on or after July 1, 1986, the Secretary of Health and Human Services shall—

(1) base such limitations on the most recent data available, which data may be for cost reporting periods beginning no earlier than October 1, 1983; and

(2) take into account the changes in costs of home health agencies for billing and verification procedures that result from the Secretary's changing the requirements for such procedures, to the extent the changes in costs are not reflected in such data.

Paragraph (2) shall apply to changes in requirements effected before, on, or after July 1, 1986.

42 USC 1395x
note.

(c) **GAO REPORT.**—The Comptroller General shall study and report to Congress, not later than February 1, 1988, on—

(1) the appropriateness and impact on medicare beneficiaries of applying the per visit cost limits for home health services under section 1861(v)(1)(L) of the Social Security Act on a discipline-specific basis, rather than on an aggregate basis, for all home health services furnished by an agency, and

(2) the appropriateness of the percentage limits established under such section.

SEC. 9316. ESTABLISHMENT OF PATIENT OUTCOME ASSESSMENT RESEARCH PROGRAM.

(a) **IN GENERAL.**—Section 1875 of the Social Security Act (42 U.S.C. 139511) is amended by adding at the end the following new subsection:

“(c)(1) The Secretary shall establish a patient outcome assessment research program (in this subsection referred to as the ‘research program’) to promote research with respect to patient outcomes of selected medical treatments and surgical procedures for the purpose of assessing their appropriateness, necessity, and effectiveness. The research program shall include—

“(A) reorganization of data relating to claims under parts A and B of this title in a manner that facilitates research with respect to patient outcomes,

“(B) assessments of the appropriateness of admissions and discharges,

“(C) assessments of the extent of professional uncertainty regarding efficacy,

“(D) development of improved methods for measuring patient outcomes,

“(E) evaluations of patient outcomes, and

“(F) evaluation of the effects on physicians’ practice patterns of the dissemination to physicians and peer review organizations with contracts under part B of title XI of the findings of the research conducted under subparagraphs (B), (C), (D), and (E).

“(2) In selecting treatments and procedures to be studied, the Secretary shall give priority to those medical and surgical treatments and procedures—

“(A) for which data indicate a highly (or potentially highly) variable pattern of utilization among beneficiaries under this title in different geographic areas, and

Physicians.
Contracts.

42 USC 1320c.

“(B) which are significant (or potentially significant) for purposes of this title in terms of utilization by beneficiaries, length of hospitalization associated with the treatment or procedure, costs to the research program, and risk involved to the beneficiary.

“(3) For purposes of carrying out the research program, there are authorized to be appropriated—

Appropriation
authorization.

“(A) from the Federal Hospital Insurance Trust Fund \$4,000,000 for fiscal year 1987 and \$5,000,000 for each of fiscal years 1988 and 1989, and

“(B) from the Federal Supplementary Medical Insurance Trust Fund \$2,000,000 for fiscal years 1987 and \$2,500,000 for each of fiscal years 1988 and 1989.

“(4) Not less than 90 percent of the amount appropriated for any fiscal year to carry out the research program shall be used to fund grants to, and cooperative agreements with, non-Federal entities to conduct research described in paragraph (1). The remainder may be used by the Secretary to provide such research by Federal entities and for administrative costs.

“(5) The research program shall be administered by the National Center for Health Services Research and Health Care Technology established under section 305 of the Public Health Service Act (in this subsection referred to as the ‘Center’). The Center shall establish application procedures for grants and cooperative agreements, and shall establish peer review panels to review all such applications and all research findings. The Center shall consult with the council on health care technology (established under a grant under section 309 of the Public Health Service Act) in establishing the scope and priorities for the research program and shall report periodically to any such council on the status of the program.

Grants.
Contracts.
42 USC 242c.

“(6) The Secretary shall make available data derived from the programs under this title and other programs administered by the Secretary for use in the research program.

Reports.
42 USC 242n.

“(7) The Center shall report to the Committees on Finance and Appropriations of the Senate and the Committees on Ways and Means, Energy and Commerce, and Appropriations of the House of Representatives not later than 18 months after the date of the enactment of this Act, and annually thereafter, with respect to the findings under the research program. In cooperation with appropriate medical specialty groups, the Center shall disseminate such findings as widely as possible, including disseminating such findings to each peer review organization which has a contract under part B of title XI.”

Reports.
Contracts.

42 USC 1320c.

(b) **PERMITTING SERVICES TO BE PROVIDED UNDER RESEARCH PROGRAM.**—Section 1862(a)(1) of such Act (42 U.S.C. 1395y(a)(1)) is amended—

(1) by striking “and” at the end of subparagraph (C),

(2) by striking the semicolon at the end of subparagraph (D) and inserting “, and”, and

(3) by adding at the end the following new subparagraph:

“(E) in the case of research conducted pursuant to section 1875(c), which is not reasonable and necessary to carry out the purposes of that section;”.

Ante, p. 2006.

SEC. 9317. IMPROVEMENTS IN CIVIL MONETARY PENALTY AND EXCLUSION PROVISIONS.

(a) **COLLATERAL ESTOPPEL EFFECT OF PRIOR FEDERAL CRIMINAL CONVICTIONS.**—Section 1128A(c) of the Social Security Act (42 U.S.C. 1320a-7a(c)), as redesignated by section 9313(c), is amended by adding at the end the following new paragraph:

“(3) In a proceeding under subsection (a) or (b) which—

“(A) is against a person who has been convicted (whether upon a verdict after trial or upon a plea of guilty or nolo contendere) of a Federal crime charging fraud or false statements, and

“(B) involves the same transaction as in the criminal action, the person is estopped from denying the essential elements of the criminal offense.”.

(b) **AUTHORITY OF HEARING OFFICER TO SANCTION MISCONDUCT.**—Such section is further amended by adding at the end the following new paragraph:

“(4) The official conducting a hearing under this section may sanction a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing. Such sanction shall reasonably relate to the severity and nature of the failure or misconduct. Such sanction may include—

“(A) in the case of refusal to provide or permit discovery, drawing negative factual inferences or treating such refusal as an admission by deeming the matter, or certain facts, to be established,

“(B) prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense,

“(C) striking pleadings, in whole or in part,

“(D) staying the proceedings,

“(E) dismissal of the action,

“(F) entering a default judgment,

“(G) ordering the party or attorney to pay attorneys’ fees and other costs caused by the failure or misconduct, and

“(H) refusing to consider any motion or other action which is not filed in a timely manner.”.

(c) **CLARIFICATION OF EXCLUSION AUTHORITY FOR CERTAIN OFFENDERS.**—Section 1128 of such Act (42 U.S.C. 1320a-7) is amended by adding at the end the following new subsection:

“(f) For purposes of subsection (a), a physician or other individual is considered to have been ‘convicted’ of a criminal offense—

“(1) when a judgment of conviction has been entered against the physician or individual by a Federal, State, or local court, regardless of whether there is an appeal pending or whether the judgment of conviction or other record relating to criminal conduct has been expunged;

“(2) when there has been a finding of guilt against the physician or individual by a Federal, State, or local court;

“(3) when a plea of guilty or nolo contendere by the physician or individual has been accepted by a Federal, State, or local court; or

“(4) when the physician or individual has entered into participation in a first offender or other program where judgment of conviction has been withheld.”.

Physicians.
State and local
governments.

(d) **EFFECTIVE DATES.**—(1) The amendment made by subsection (a) shall take effect on the date of the enactment of this Act, without regard to when the criminal conviction was obtained, but shall only apply to a conviction upon a plea of *nolo contendere* tendered after the date of the enactment of this Act.

42 USC 1320a-7a
note.

(2) The amendment made by subsection (b) shall apply to failures or misconduct occurring on or after the date of the enactment of this Act.

(3) The provisions—

42 USC 1320a-7
note.

(A) of paragraphs (1), (2), and (3) of section 1128(f) of the Social Security Act (as added by the amendment made by subsection (c)) shall apply to judgments entered, findings made, and pleas entered, before, on, or after the date of the enactment of this Act, and

Ante, p. 2008.

(B) of paragraph (4) of such section shall apply to participation in a program entered into on or after the date of the enactment of this Act.

SEC. 9318. HOSPITAL PROTOCOLS FOR ORGAN PROCUREMENT AND STANDARDS FOR ORGAN PROCUREMENT AGENCIES.

(a) **IN GENERAL.**—Title XI of the Social Security Act is amended by inserting after section 1137 the following new section:

“HOSPITAL PROTOCOLS FOR ORGAN PROCUREMENT AND STANDARDS FOR ORGAN PROCUREMENT AGENCIES

“SEC. 1138. (a)(1) The Secretary shall provide that a hospital meeting the requirements of title XVIII or XIX may participate in the program established under such title only if—

42 USC 1320b-8
42 USC 1395,
1396.

“(A) the hospital establishes written protocols for the identification of potential organ donors that—

“(i) assure that families of potential organ donors are made aware of the option of organ or tissue donation and their option to decline,

“(ii) encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of such families, and

“(iii) require that an organ procurement agency designated by the Secretary pursuant to subsection (b)(1)(F) be notified of potential organ donors; and

“(B) In the case of a hospital in which organ transplants are performed, the hospital is a member of, and abides by the rules and requirements of, the Organ Procurement and Transplantation Network established pursuant to section 372 of the Public Health Service Act (in this section referred to as the ‘Network’).

42 USC 274.

“(2) For purposes of this subsection, the term ‘organ’ means a human kidney, liver, heart, lung, pancreas, and any other human organ or tissue specified by the Secretary for purposes of this subsection.

“(b)(1) The Secretary shall provide that payment may be made under title XVIII or XIX with respect to organ procurement costs attributable to payments made to an organ procurement agency only if the agency—

“(A)(i) is a qualified organ procurement organization (as described in section 371(b) of the Public Health Service Act) that is operating under a grant made under section 371(a) of such Act, or (ii) has been certified or recertified by the Secretary within

42 USC 273.

the previous two years as meeting the standards to be a qualified organ procurement organization (as so described);

“(B) meets the requirements that are applicable under such title for organ procurement agencies;

“(C) meets performance-related standards prescribed by the Secretary;

“(D) is a member of, and abides by the rules and requirements of, the Network;

“(E) allocates organs, within its service area and nationally, in accordance with medical criteria and the policies of the Network; and

“(F) is designated by the Secretary as an organ procurement organization payments to which may be treated as organ procurement costs for purposes of reimbursement under such title.

“(2) The Secretary may not designate more than one organ procurement organization for each service area (described in section 371(b)(1)(E) of the Public Health Service Act) under paragraph (1)(F).”.

42 USC 273.

42 USC 1320b-8
note.

42 USC 1395,
1396.

(b) **EFFECTIVE DATES.**—(1) Section 1138(a) of the Social Security Act shall apply to hospitals participating in the programs under titles XVIII and XIX of such Act as of October 1, 1987.

(2) Section 1138(b) of such Act shall apply to costs of organs procured on or after October 1, 1987.

SEC. 9319. MEDICARE AS SECONDARY PAYER; COVERAGE REQUIREMENTS FOR CERTAIN OTHER PAYERS.

(a) **MEDICARE SECONDARY FOR DISABLED EMPLOYEES OF CERTAIN LARGE EMPLOYERS.**—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following new paragraph:

“(4)(A)(i) A large group health plan may not take into account that an active individual is eligible for or receives benefits under this title under section 226(b), other than an individual who is, or would upon application be, entitled to benefits under section 226A.

42 USC 426.

42 USC 426-1.

“(ii) Payment may not be made under this title, except as provided in clause (iii), with respect to any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to the item or service as required under clause (i).

Claims.

“(iii) Any payment under this title with respect to any item or service to which clause (i) applies shall be conditioned on reimbursement to the appropriate Trust Fund established by this title. In order to recover payment made under this title for the item or service, the United States may bring an action against any entity which is required under this subsection (a) to pay with respect to the item or service (and may, in accordance with paragraph (5), collect double damages against that entity), or against any other entity that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service. The United States shall be subrogated (to the extent of payment made under this title for an item or service) to any right under clause (i) of an individual or any other entity to payment with respect to the item or service. The Secretary may waive (in whole or in part) the provisions of this clause in the case of an individual claim if the Secretary determines that the waiver is in the best interests of the program established under this title.

“(B) In this paragraph:

“(i) The term ‘large group health plan’ has the meaning given such term in section 5000(b) of the Internal Revenue Code of 1986.

“(ii) The term ‘active individual’ means an employee (as may be defined in regulations), the employer, an individual associated with the employer in a business relationship, or a member of the family of any of those persons.

“(C) The provisions of subparagraph (B) of paragraph (3) shall apply to coordination of payment under this paragraph in the case of large group health plans in the same manner as they apply to coordination of payment under paragraph (3) in the case of group health plans.

“(D) The preceding provisions of this paragraph shall only apply to items and services furnished on or after January 1, 1987, and before January 1, 1992.”.

(b) ESTABLISHMENT OF PRIVATE CAUSE OF ACTION WHERE MEDICARE SECONDARY.—Such section is further amended by adding at the end the following new paragraph:

“(5) There is hereby created a private cause of action for damages (which shall be in an amount double the amount otherwise provided) in the case of a workmen’s compensation law or plan, automobile or liability insurance policy or plan or no fault insurance plan, group health plan, or large group health plan which is made a primary payer under paragraph (1), (2), (3), or (4), respectively, and which fails to provide for primary payment (or appropriate reimbursement) in accordance with such respective paragraphs.”

Post, p. 2095.

Insurance.

(c) SPECIAL ENROLLMENT PERIODS.—

(1) Section 1837(i)(1) of such Act (42 U.S.C. 1395p(i)(1)) is amended by adding at the end the following: “In the case of an individual who has not attained the age of 65, at the time the individual first satisfies paragraph (1) of section 1836, is enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(4)(B)), and has elected not to enroll (or to be deemed enrolled) under this section during the individual’s initial enrollment period, there shall be a special enrollment period described in paragraph (3)(B).”.

42 USC 1395o.

42 USC 1395y.

(2) Section 1837(i)(2) of such Act (42 U.S.C. 1395p(i)(2)) is amended by adding at the end the following: “In the case of an individual who has not attained the age of 65, has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual’s initial enrollment period, or is an individual described in the second sentence of paragraph (1), has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(4)(B)), and has not terminated enrollment under this section at any time at which the individual is not enrolled in such a large group health plan as an active individual, there shall be a special enrollment period described in paragraph (3)(B).”.

(3) Section 1837(i)(3) of such Act (42 U.S.C. 1395p(i)(3)) is amended—

Ante, p. 171.

(A) by inserting “(A)” after “(3)”,

(B) by inserting “the first sentences of” after “referred to in”,

(C) by adding at the end the following new subparagraph:

“(B) The special enrollment period referred to in the second sentences of paragraphs (1) and (2) is the period beginning with the first day of the first month in which the individual is no longer enrolled as an active individual in a large group health plan (as such terms are defined in section 1862(b)(4)(B)) and ending seven months later.”.

42 USC 1395y.

(4) The second sentence of section 1839(b) of such Act (42 U.S.C. 1395(b)) is amended by inserting before the period the following: “or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(4)(B))”.

(d) TAX IMPOSED ON NONCONFORMING PLANS.—

Post, p. 2095.

(1) Subtitle D of the Internal Revenue Code of 1954 (relating to miscellaneous excise taxes) is amended by adding at the end the following new chapter:

“CHAPTER 47—CERTAIN LARGE GROUP HEALTH PLANS

“Sec. 5000. Certain large group health plans.

26 USC 5000.

“SEC. 5000. CERTAIN LARGE GROUP HEALTH PLANS.

“(a) IMPOSITION OF TAX.—There is hereby imposed on any employer or employee organization that contributes to a nonconforming large group health plan a tax equal to 25 percent of the employer’s or employee organization’s expenses incurred during the calendar year for each large group health plan to which the employer or employee organization contributes.

“(b) LARGE GROUP HEALTH PLAN.—For purposes of this section, the term ‘large group health plan’ means a plan of, or contributed to by, an employer or employee organization (including a self-insured plan) to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families, that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year.

“(c) NONCONFORMING LARGE GROUP HEALTH PLAN.—For purposes of this section, the term ‘nonconforming large group health plan’ means a large group health plan that at any time during a calendar year does not comply with the requirements of section 1862(b)(4)(A)(i) of the Social Security Act.

42 USC 1395y.

“(d) GOVERNMENT ENTITIES.—For purposes of this section, the term ‘employer’ does not include a Federal or other governmental entity.”.

(2) The table of chapters of subtitle D of such Code is amended by adding at the end thereof the following:

“CHAPTER 47. Certain large group health plans.”.

(e) STUDY OF IMPACT ON DISABLED BENEFICIARIES AND FAMILY.—The Comptroller General shall study and report to Congress, by not later than March 1, 1990, the impact of the amendments made by this section on access of disabled individuals and members of their family to employment and health insurance. The report shall include information relating to—

Reports.
42 USC 1395y
note.

(1) the number of disabled medicare beneficiaries for whom medicare has become secondary, either through their employment or the employment of a family member;

(2) the amount of savings to the medicare program achieved annually through this provision; and

(3) the effect on employment, and employment-based health coverage, of disabled individuals and family members.

(f) EFFECTIVE DATES.—

(1) Except as provided in paragraph (2), the amendments made by this section shall apply to items and services furnished on or after January 1, 1987.

(2) The amendments made by subsection (c) shall apply to enrollments occurring on or after January 1, 1987.

42 USC 1395y
note.

SEC. 9320. PAYMENT FOR SERVICES OF CERTIFIED REGISTERED NURSE ANESTHETISTS.

(a) EXTENSION OF PASS-THROUGH FOR COSTS OF CERTIFIED REGISTERED NURSE ANESTHETISTS.—Section 2312(c) of the Deficit Reduction Act of 1984 is amended by striking “October 1, 1987.” and inserting “January 1, 1989. In the case of a cost reporting period that begins before January 1, 1989, but end after such date, additional payments under the amendment made by subsection (a) shall be proportionately reduced to reflect the portion of the period occurring after such date.”.

42 USC 1395ww
note.

(b) COVERAGE OF SERVICES OF A CERTIFIED REGISTERED NURSE ANESTHETIST UNDER PART B.—Section 1861(s) of the Social Security Act (42 U.S.C. 1395x(s)) is amended—

(1) by redesignating paragraphs (11) through (14) as paragraphs (12) through (15), respectively;

(2) by striking “and” at the end of paragraph (9);

(3) by striking the period at the end of paragraph (10) and inserting “; and”; and

(4) by inserting after paragraph (10) the following new paragraph:

“(11) services of a certified registered nurse anesthetist (as defined in subsection (bb)).”.

(c) DEFINITION OF SERVICES OF A CERTIFIED REGISTERED NURSE ANESTHETIST.—Section 1861 of such Act is amended by inserting after subsection (aa) the following new subsection:

“SERVICES OF A CERTIFIED REGISTERED NURSE ANESTHETIST

“(bb)(1) The term ‘services of a certified registered nurse anesthetist’ means anesthesia services and related care furnished by a certified registered nurse anesthetist (as defined in paragraph (2)) which the nurse anesthetist is legally authorized to perform as such by the State in which the services are furnished.

“(2) The term ‘certified registered nurse anesthetist’ means a certified registered nurse anesthetist licensed by the State who meets such education, training, and other requirements relating to anesthesia services and related care as the Secretary may prescribe. In prescribing such requirements the Secretary may use the same requirements as those established by a national organization for the certification of nurse anesthetists.”.

(d) DIRECT PAYMENT FOR SERVICES.—Section 1832(a)(2)(B) of such Act (42 U.S.C. 1395k(a)(2)(B)) is amended—

(1) by striking “and” at the end of clause (i),

(2) by striking “; and” at the end of clause (ii) and inserting “, and”, and

(3) by adding at the end the following new clause:

“(iii) services of a certified registered nurse anesthetist; and”.

(e) AMOUNT OF PAYMENT.—(1) Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) is amended by striking “and” at the end of subparagraph (E), and by adding at the end the following: “and (H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule for such services established by the Secretary in accordance with subsection (l).”.

(2) Section 1833 of such Act is further amended by adding at the end the following new subsection:

“(1)(1) The Secretary shall establish a fee schedule for services of certified registered nurse anesthetists under section 1861(s)(11).

“(2) Except as provided in paragraph (3), the fee schedule established under paragraph (1) shall be initially based on audited data from cost reporting periods ending in fiscal year 1985. The fee schedule shall be adjusted annually (to become effective on January 1 of each calendar year) by the percentage increase in the MEI (as defined in section 1842(b)(4)(E)(ii)) for that year.

“(3)(A) In establishing the initial fee schedule for those services, the Secretary shall adjust the fee schedule to the extent necessary to ensure that the estimated total amount which will be paid under this title for those services plus applicable coinsurance in 1989 will equal the estimated total amount which would be paid under this title for those services in 1989 if the services were included as inpatient hospital services and payment for such services was made under part A in the same manner as payment was made in fiscal year 1987, adjusted to take into account changes in prices and technology relating to the administration of anesthesia.

“(B) The Secretary shall also reduce the prevailing charge of physicians for medical direction of a certified registered nurse anesthetist, or the fee schedule for services of certified registered nurse anesthetists, or both, to the extent necessary to ensure that the estimated total amount which will be paid under this title plus applicable coinsurance for such medical direction and such services in 1989 and 1990 will not exceed the estimated total amount which would have been paid but for the enactment of the amendments made by section 9320 of the Omnibus Budget Reconciliation Act of 1986. A reduced prevailing charge under this subparagraph shall become the prevailing charge but for subsequent years for purposes of applying the economic index under the fourth sentence of section 1842(b)(3).

“(4) In establishing the fee schedule under paragraph (1), the Secretary may utilize a system of time units, a system of base and time units, or any appropriate methodology. The Secretary may establish a nationwide fee schedule or adjust the fee schedule for geographic areas (as the Secretary may determine to be appropriate).

“(5)(A) Payment for the services of a certified registered nurse anesthetist (for which payment may otherwise be made under this part) may be made on the basis of a claim or request for payment presented by the certified registered nurse anesthetist furnishing such services, or by a hospital, physician, or group practice with which the certified registered nurse anesthetist furnishing such

Ante, p. 2013.

Effective date.

42 USC 1395u.

Physicians.

Claims.
Contracts.

services has an employment or contractual relationship that provides for payment to be made under this part for such services to such hospital, physician, or group practice.

“(B)(i) Payment for the services of a certified registered nurse anesthetist under this part may be made only on an assignment-related basis, and any such assignment agreed to by a certified registered nurse anesthetist shall be binding upon any other person presenting a claim or request for payment for such services.

“(ii) Except for deductible and coinsurance amounts applicable under this section, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services of a certified registered nurse anesthetist for which payment may be made under this part only on an assignment-related basis is subject to a civil monetary penalty of not to exceed \$2,000 for each such bill or request. Such a penalty shall be imposed in the same manner as civil monetary penalties are imposed under section 1128A with respect to actions described in subsection (a) of that section.

Ante, pp. 2003, 2008.

“(C) No hospital that presents a claim or request for payment for services of a certified nurse anesthetist under this part may treat any uncollected coinsurance amount imposed under this part with respect to such services as a bad debt of such hospital for purposes of this title.

Claims.

“(6)(A) If an adjustment under paragraph (3)(B) results in a reduction in the reasonable charge for a physicians’ service and a nonparticipating physician furnishes the service to an individual entitled to benefits under this part (subject to subparagraph (D)), the physician may not charge the individual more than the limiting charge (as defined in subparagraph (B)) plus (for services furnished during the 12-month period beginning on the effective date of the reduction) ½ of the amount by which the physician’s actual charges for the service for the previous 12-month period exceeds the limiting charge.

Physicians.

“(B) In subparagraph (A), the term ‘limiting charge’ means, with respect to a service, 125 percent of the prevailing charge for the service after the reduction referred to in subparagraph (A).

“(C) If a physician knowingly and willfully imposes charges in violation of subparagraph (A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

Physicians.
Sanctions.

“(D) This paragraph shall not apply to services furnished after the earlier of (i) December 31, 1990, or (ii) one-year after the date the Secretary reports to Congress, under section 1845(e)(3), on the development of the relative value scale under section 1845.”.

Reports.

Ante, p. 190.

(3) Section 1842(j)(2) of such Act (42 U.S.C. 1395u(j)(2)) is amended by striking “paragraph (1) or subsection (k)” and inserting “this paragraph”.

(f) NOT TREATED AS PART OF INPATIENT HOSPITAL SERVICES.—Section 1861(b)(4) of such Act (42 U.S.C. 1395x(b)(4)) is amended by inserting before the semicolon the following: “, anesthesia services provided by a certified certified registered nurse anesthetist”.

(g) CONFORMING AMENDMENTS TO HOSPITAL PAYMENTS.—(1) Section 1886(a)(4) of such Act (42 U.S.C. 1395ww(a)(4)) is amended by striking “, costs of anesthesia services provided by a certified registered nurse anesthetist,”.

(2) Section 1886(d)(5) of such Act (42 U.S.C. 1395ww(d)(5)) is amended by striking subparagraph (E).

(h) **OTHER CONFORMING AMENDMENTS.**—(1) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by inserting before the period the following: “or are services of a certified registered nurse anesthetist”.

(2) Section 1866(a)(1)(H) of such Act (42 U.S.C. 1395cc(a)(1)(H)) is amended by inserting “, and other than services of a certified registered nurse anesthetist” after “1862(a)(14)”.

(3) Sections 1864(a), 1865(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) of such Act (42 U.S.C. 1395aa(a), 1395bb(a), 1396a(a)(9)(C), 1396n(a)(1)(B)(ii)(I)) are each amended by striking “paragraphs (11) and (12)” and inserting “paragraphs (12) and (13)”.

(i) **EFFECTIVE DATE.**—The amendments made by this section (other than subsection (a)) shall apply to services furnished on or after January 1, 1989.

(j) **CONSTRUCTION.**—Nothing in this section or the amendments made by this section shall contravene provisions of State law relating to the practice of medicine or nursing or State law requirements or institutional requirements regarding the administration of anesthesia and its medical direction or supervision.

SEC. 9321. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PARTS A AND B.

(a) TREATMENT OF GROUP PURCHASING VENDOR AGREEMENTS.—

(1) **IN GENERAL.**—Section 1877(b)(3) of the Social Security Act (42 U.S.C. 1395nn(b)(3)) is amended—

(A) by striking “and” at the end of subparagraph (A),

(B) by striking the period at the end of subparagraph (B) and inserting “; and”, and

(C) by adding at the end the following:

“(C) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under this title if—

“(i) the person has a written contract, with each such individual or entity which specifies the amount to be paid the person, which amount may be a fixed amount or a fixed percentage of the value of the purchases made by each such individual or entity under the contract, and

“(ii) in the case of an entity that is a provider of services, the person discloses (in such form and manner as the Secretary requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity.”.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) apply to payments made before, on, or after the date of the enactment of this Act.

(b) **EXTENSION AND CLARIFICATION OF COMPETITIVE CONTRACTING AUTHORITY.**—Section 2326(a) of the Deficit Reduction Act of 1984 is amended—

(1) by striking “of the fiscal years” and all that follows through “, the Secretary” and inserting “fiscal year (beginning with fiscal year 1985 and ending with fiscal year 1989), the Secretary”, and

(2) by inserting “or cost reimbursement provisions under sections 1816(c) or 1842(c) of such Act” after “such Act” the second place it appears.

(c) **TREATMENT OF CAPITAL-RELATED REGULATIONS.**—

42 USC 1395k
note.

42 USC 1395k
note.

Contracts.

42 USC 1395nn
note.

42 USC 1395h
note.

Ante, pp. 1997,
1998.

42 USC 1395ww
note.

(1) PROHIBITION OF ISSUANCE OF FINAL REGULATIONS ON CAPITAL-RELATED COSTS AS PART OF PAYMENT FOR OPERATING COSTS BEFORE SEPTEMBER 1, 1987.—Notwithstanding any other provision of law (except as provided in paragraph (3)), the Secretary of Health and Human Services may not issue, in final form, after September 1, 1986, and before September 1, 1987, any regulation that changes the methodology for computing the amount of payment for capital-related costs (as defined in paragraph (4)) for inpatient hospital services under part A of title XVIII of the Social Security Act. Any regulation published in violation of the previous sentence before the date of the enactment of this Act is void and of no effect.

42 USC 1395c.

(2) NOT INCLUDING CAPITAL-RELATED REGULATIONS IN BUDGET BASELINE.—Any reference in law to a regulation issued in final form or proposed by the Health Care Financing Administration pursuant to sections 1886(b)(3)(B), 1886(d)(3)(A), and 1886(e)(4) of the Social Security Act shall not include any regulation issued or proposed with respect to capital-related costs (as defined in paragraph (4)).

42 USC 1395ww.

(3) EXCEPTION.—Paragraph (1) shall not apply to any regulation issued for the sole purpose of implementing section 1886(g)(3)(A) and (B) of the Social Security Act (as amended by section 9303(a) of this Act).

(4) CAPITAL-RELATED COSTS DEFINED.—In this subsection, the term “capital-related costs” means those capital-related costs that are specifically excluded, under the second sentence of “operating costs of inpatient hospital services” (as defined in that section) for cost reporting periods beginning prior to October 1, 1987.

(d) LIMITATION ON AUTHORITY TO ISSUE CERTAIN FINAL REGULATIONS AND INSTRUCTIONS RELATING TO HOSPITALS OR PHYSICIANS.—Notwithstanding any other provision of law, except as required to implement specific provisions required under statute and except as provided under subsection (c) with respect to a regulation described in that subsection, the Secretary of Health and Human Services is not authorized to issue in final form after the date of the enactment of this Act and before September 1, 1987, any regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act in fiscal year 1988 of more than \$50,000,000, and which relates to hospitals or physicians.

42 USC 1395ww
note.

(e) 60-DAY NOTICE FOR PROPOSED REGULATIONS.—

42 USC 1395.

(1) IN GENERAL.—Section 1871 of the Social Security Act (42 U.S.C. 1395hh) is amended by inserting “(a)” after “1871.” and by adding at the end the following new subsection:

“(b)(1) Except as provided in paragraph (2), before issuing in final form any regulation under subsection (a), the Secretary shall provide for notice of the proposed regulation in the Federal Register and a period of not less than 60 days for public comment thereon.

Federal
Register,
publication.

“(2) Paragraph (1) shall not apply where—

“(A) a statute specifically permits a regulation to be issued in interim final form or otherwise with a shorter period for public comment,

“(B) a statute establishes a specific deadline for the implementation of a provision and the deadline is less than 150 days after the date of the enactment of the statute in which the deadline is contained, or

“(C) subsection (b) of section 553 of title 5, United States Code, does not apply pursuant to subparagraph (B) of such subsection.”.

(2) **CONFORMING AMENDMENTS.**—(A) Section 1886(e)(3)(A) of such Act (42 U.S.C. 1395ww(e)(3)(A)), as amended by section 9302(e)(3)(B), is amended by striking “April” and inserting “March”.

(B) Section 1886(e)(5)(A) of such Act is amended by striking “June” and inserting “May”.

(3) **EFFECTIVE DATES.**—

(A) The amendments made by paragraph (1) shall apply to notices of proposed rulemaking issued after the date of the enactment of this Act.

(B) The amendments made by paragraph (2) shall take effect beginning with fiscal year 1989.

42 USC 1395hh
note.

42 USC 1395ww
note.

PART 3—PROVISIONS RELATING TO MEDICARE PART B

SEC. 9331. PAYMENT FOR PHYSICIANS' SERVICES.

(a) **DETERMINATION OF MAXIMUM ALLOWABLE PREVAILING CHARGES FOR PHYSICIANS' SERVICES.**—

(1) **IN GENERAL.**—Section 1842(b)(4)(A) of the Social Security Act (42 U.S.C. 1395u(b)(4)(A)) is amended by striking clause (iii) and inserting the following:

“(iii) In determining the maximum allowable prevailing charges which may be recognized consistent with the index described in the fourth sentence of paragraph (3) for physicians' services furnished on or after January 1, 1987, by participating physicians, the Secretary shall treat the maximum allowable prevailing charges recognized as of December 31, 1986, under such sentence with respect to participating physicians as having been justified by economic changes.

“(iv) In determining the prevailing charge level under the third and fourth sentences of paragraph (3) for a physicians' service furnished on or after January 1, 1987, by a nonparticipating physician, the Secretary shall set the level at 96 percent of the prevailing charge levels established under such sentences with respect to such service furnished by participating physicians.

“(v) Beginning with 1987, the percentage increase in the MEI (as defined in subparagraph (E)(ii)) for each year shall be the same for nonparticipating physicians as for participating physicians.”.

(2) **CONFORMING AMENDMENT.**—Section 1842(b)(4)(C) of such Act is amended—

(A) by striking “(i)” after “(C)”, and

(B) by striking clause (ii).

(3) **DEFINITIONS.**—Section 1842(b)(4) of such Act is further amended by adding at the end the following new subparagraph:

“(E) In this section:

“(i) The term ‘participating physician’ refers, with respect to the furnishing of services, to a physician who at the time of furnishing the services is a participating physician (under subsection (h)(1)), and the term ‘nonparticipating physician’ refers, with respect to the furnishing of services, a physician who at the time of furnishing the services is not a participating physician.

“(ii) The term ‘percentage increase in the MEI’ means, with respect to physicians’ services furnished in a year, the percentage increase in the medicare economic index (referred to in the fourth sentence of paragraph (3)) applicable to such services furnished as of the first day of that year.”.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 1987.

42 USC 1395u
note.

(b) GENERAL LIMIT ON ACTUAL CHARGES FOR NONPARTICIPATING PHYSICIANS.—

42 USC 1395u.

(1) IN GENERAL.—Section 1842(j)(1) of such Act is amended—

(A) by inserting “(A)” after “(j)(1)”, and

(B) by adding at the end the following new subparagraph:

“(B)(i) During any period (on or after January 1, 1987, and before the date specified in clause (ii)), during which a physician is a nonparticipating physician, the Secretary shall monitor each such physician’s actual charges for physicians’ services furnished to individuals enrolled under this part. If such physician knowingly and willfully bills for such a service a physician’s actual charge (as defined in subparagraph (C)(vi) in excess of the maximum allowable actual charge determined under subparagraph (C) for that service, the Secretary may apply sanctions against such physician in accordance with paragraph (2).

Sanctions.

“(ii) Clause (i) shall not apply to services furnished after the earlier of (I) December 31, 1990, or (II) one-year after the date the Secretary reports to Congress, under section 1845(e)(3), on the development of the relative value scale under section 1845.

Ante, p. 190.

“(C)(i) For a particular physicians’ service furnished by a nonparticipating physician to individuals enrolled under this part during a year, for purposes of subparagraph (B), the maximum allowable actual charge is determined as follows: If the physician’s actual charge for that service in the previous year was—

“(I) less than 115 percent of the prevailing charge for the year involved for such service furnished by nonparticipating physicians, the maximum allowable actual charge for the year involved is the greater of the maximum allowable actual charge described in subclause (II) or the charge described in clause (ii), or

“(II) equal to, or greater than, 115 percent of the prevailing charge for the year involved for such service furnished by nonparticipating physicians, the maximum allowable actual charge is 101 percent of the physician’s maximum allowable actual charge for the service for the previous year.

“(ii) For purposes of clause (i)(I), the charge described in this clause for a particular physicians’ service furnished in a year is the maximum allowable actual charge for the service of the physician for the previous year plus the product of (I) the applicable fraction (as defined in clause (iii)) and (II) the amount by which 115 percent of the prevailing charge for the year involved for such service furnished by nonparticipating physicians, exceeds the physician’s maximum allowable actual charge for the service for the previous year.

“(iii) In clause (ii), the ‘applicable fraction’ is—

“(I) for 1987, $\frac{1}{4}$,

“(II) for 1988, $\frac{1}{3}$,

“(III) for 1989, $\frac{1}{2}$, and

“(IV) for any subsequent year, 1.

“(iv) For purposes of determining the maximum allowable actual charge under clauses (i) and (ii) for 1987, in the case of a physicians’ service for which the physician has actual charges for the calendar quarter beginning on April 1, 1984, the ‘maximum allowable actual charge’ for 1986 is the physician’s actual charge for such service furnished during such quarter.

“(v) For purposes of determining the maximum allowable actual charge under clauses (i) and (ii) for a year after 1987, in the case of a physicians’ service for which the physician has no actual charges for the calendar quarter beginning on April 1, 1984, and for which a maximum allowable actual charge has not been previously established under this clause, the ‘maximum allowable actual charge’ for the previous year shall be the 50th percentile of the customary charges for the service (weighted by frequency of the service) performed by nonparticipating physicians in the locality during the 12-month period ending June 30 of that previous year.

“(vi) For purposes of this subparagraph and subparagraph (B), a ‘physician’s actual charge’ for a physicians’ service furnished in a year or other period is the weighted average (or, at the option of the Secretary for a service furnished in the calendar quarter beginning April 1, 1984, the median) of the physician’s charges for such service furnished in the year or other period.”.

42 USC 1395u.

(2) **PROVISION OF ACTUAL CHARGE INFORMATION BY CARRIER TO NONPARTICIPATING PHYSICIANS.**—Section 1842(b)(3) of such Act is amended—

- (A) by striking “and” at the end of subparagraph (E),
- (B) by inserting “and” at the end of subparagraph (F), and
- (C) by inserting after subparagraph (F) the following new subparagraph:

“(G) will provide to each nonparticipating physician, at the beginning of each year, a list of the physician’s maximum allowable actual charges (established under subsection (j)(1)(C)) for the year for the physicians’ services mostly commonly furnished by that physician;”.

(3) **CONFORMING AMENDMENT.**—Section 1842(b)(4)(D) of such Act is amended by adding at the end the following new clause:

“(iv) In determining the customary charges for a physicians’ service furnished on or after January 1, 1988, if a physician was a nonparticipating physician in a previous year (beginning with 1987), the Secretary shall not recognize any amount of such actual charges (for that service furnished during such previous year) that exceeds the maximum allowable actual charge for such service established under subsection (j)(1)(C).”.

42 USC 1395u
note.

(4) **EFFECTIVE DATE.**—The amendments made by this subsection shall apply to services furnished on or after January 1, 1987.

42 USC 1395u
note.

(c) **MEDICARE ECONOMIC INDEX.**—

42 USC 1395j.

(1) **FOR 1987.**—Notwithstanding any other provision of law, for purposes of part B of title XVIII of the Social Security Act for physicians’ services furnished in 1987, the percentage increase in the MEI (as defined in section 1842(b)(4)(E)(ii) of the Social Security Act) shall be 3.2 percent.

(2) **PROHIBITING RETROACTIVE ADJUSTMENT OF MEDICARE ECONOMIC INDEX.**—The Secretary of Health and Human Services is not authorized to revise the MEI in a manner that provides, for any period before January 1, 1985, for the substitution of a

rental equivalence or rental substitution factor for the housing component of the consumer price index.

(3) **ANNUALIZATION OF MEI.**—(A) The fourth sentence of section 1842(b)(3) of the Social Security Act (42 U.S.C. 1395u(b)(3)) is amended by inserting after “ending June 30, 1973,” the following: “or (with respect to physicians services furnished in a year after 1987) the level determined under this sentence for the previous year”, and inserting “year-to-year” before “economic changes”.

(B) The amendments made by subparagraph (A) shall apply to physicians' services furnished on or after January 1, 1988.

(4) **STUDY.**—The Secretary shall conduct a study of the extent to which the MEI appropriately and equitably reflects economic changes in the provision of the physicians' services to medicare beneficiaries. In conducting such study the Secretary shall consult with appropriate experts.

(5) **LIMITATION ON CHANGES IN MEI METHODOLOGY.**—The Secretary shall not change the methodology (including the basis and elements) used in the MEI from that in effect as of October 1, 1985, until completion of the study under paragraph (4). After the completion of the study, the Secretary may not change such methodology except after providing notice in the Federal Register and opportunity for public comment.

(6) **MEI DEFINED.**—In this subsection, the term “MEI” means the economic index referred to in the fourth sentence of section 1842(b)(3) of the Social Security Act.

(d) **DEVELOPMENT AND USE OF HCFA COMMON PROCEDURE CODING SYSTEM.**—

(1) Not later than July 1, 1989, the Secretary of Health and Human Services (in this subsection referred to as the “Secretary”), after public notice and opportunity for public comment and after consultation with appropriate medical and other experts, shall group the procedure codes contained in any HCFA Common Procedure Coding System for payment purposes to minimize inappropriate increases in the intensity or volume of services provided as a result of coding distinctions which do not reflect substantial differences in the services rendered.

(2) Not later than January 1, 1990, each carrier with which the Secretary has entered into a contract under section 1842 of the Social Security Act shall make payments under part B of title XVIII of such Act based on the grouping of procedure codes effected under paragraph (1).

(e) **RECOMMENDATIONS.**—

(1) Section 1845(e) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

“(4)(A) In making recommendations with respect to the application of the relative value scale for purposes of establishing a fee schedule, the Secretary shall—

“(i) develop and assess an appropriate index to be used for making adjustments to reflect justifiable differences in the costs of practice based upon geographic location without exacerbating the geographic maldistribution of physicians, and

“(ii) assess the advisability and feasibility of developing an appropriate adjustment to assist in attracting and retaining physicians in medically underserved areas.

42 USC 1395u note.

42 USC 1395u note.

Public information.
42 USC 1395u note.

42 USC 1395u note.

42 USC 1395u note.

Public information.

Contracts.

42 USC 1395u.
42 USC 1395j.

Ante, p. 192.

“(B) In carrying out the requirements of subparagraph (A), the Secretary shall take into consideration the recommendations made by the Physician Payment Review Commission.

“(C)(i) The Secretary shall develop an interim index under subparagraph (A)(i) prior to January 1, 1988, based upon the most accurate and recent data that are available with respect to the costs of practice.

“(ii) The Secretary shall collect data with respect to the costs of practice (including, but not limited to, data on nonphysician personnel costs, malpractice insurance costs, and commercial rents) for the purpose of refining the index under subparagraph (A)(i) prior to December 31, 1989, and periodically updating the index thereafter.

“(D) In conjunction with developing an index under subparagraph (A), the Secretary shall conduct a study of the advisability of redefining the localities designated by carriers for payment purposes.”

42 USC 1395w-1.

(2) Section 1845(b)(3) of such Act is amended by inserting “and respecting the index and the adjustment described in subsection (e)(4)(A)” after “subsection (e)”.

(3) Section 1845(e)(3) of such Act is amended—

(A) by striking “July 1, 1987” and inserting in lieu thereof “July 1, 1989”, and

(B) by striking “on or after January 1, 1988” and inserting in lieu thereof “after December 31, 1989”.

SEC. 9332. INCENTIVES FOR PHYSICIAN PARTICIPATION.

(a) RECRUITING.—

(1) CARRIER RESPONSIBILITY.—Section 1842(b)(3) of the Social Security Act (42 U.S.C. 1395u(b)(3)), as amended by section 9331(b)(2), is further amended—

(A) by striking “and” at the end of subparagraph (F),

(B) by inserting “and” at the end of subparagraph (G), and

(C) by inserting after subparagraph (G) the following new subparagraph:

“(H) if it makes determinations or payments with respect to physicians’ services, will implement—

“(i) programs to recruit and retain physicians as participating physicians in the area served by the carrier, including educational and outreach activities and the use of professional relations personnel to handle billing and other problems relating to payment of claims of participating physicians; and

“(ii) programs to familiarize beneficiaries with the participating physician program and to assist such beneficiaries in locating participating physicians;”.

(2) MEASURING CARRIER PERFORMANCE.—The Secretary of Health and Human Services shall provide, in the standards and criteria established under section 1842(b)(2) of the Social Security Act for contracts under that section, a system to measure a carrier’s performance of the responsibilities described in sections 1842(b)(3)(H) and 1842(h) of such Act.

(3) CARRIER BONUSES FOR GOOD PERFORMANCE.—Of the amounts appropriated for administrative activities to carry out part B of title XVIII of the Social Security Act, the Secretary of Health and Human Services shall provide payments, totaling 1

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42 USC 1395u
note.

42 USC 1395u
note.

42 USC 1395j.

percent of the total payments to carriers for claims processing in any fiscal year, to carriers under section 1842 of such Act, to reward such carriers for their success in increasing the proportion of physicians in the carrier's service area who are participating physicians.

(4) EFFECTIVE DATES.—

(A) CARRIER RESPONSIBILITY.—The amendment made by paragraph (1) shall be effective for contracts under section 1842 of the Social Security Act as of October 1, 1987.

(B) PERFORMANCE MEASURES.—The Secretary of Health and Human Services shall provide for the establishment of the standards and criteria required under paragraph (2) by not later than October 1, 1987, which shall apply to contracts as of October 1, 1987.

(C) CARRIER BONUSES.—From the amounts appropriated for each fiscal year (beginning with fiscal year 1988), the Secretary of Health and Human Services shall first provide for payments of bonuses to carriers under paragraph (3) not later than April 1, 1988, to reflect performance of carriers during the enrollment period at the end of 1987.

(b) DIRECTORIES OF PARTICIPATING PHYSICIANS.—

(1) REQUIRING DISTRIBUTION TO MEDICARE BENEFICIARIES, UPON REQUEST.—Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended—

(A) in paragraph (2), by striking period and inserting the following: “and may request a copy of an appropriate directory published under paragraph (4). Each such carrier shall, without charge, mail a copy of such directory upon such a request.”;

(B) in paragraph (5)—

(i) by striking “publication of the directories” and inserting “the participation program under this subsection and the publication and availability of the directories”, and

(ii) by adding at the end the following: “The Secretary shall include such notice in the mailing of appropriate benefit checks provided under title II.”; and

(C) in the second sentence of paragraph (6)—

(i) by inserting before the period the following: “and that an appropriate number of copies of each such directory is sent to hospitals located in the area”, and

(ii) by adding at the end the following: “Such copies shall be sent free of charge.”.

(2) ORGANIZATION OF DIRECTORIES.—Section 1842(h)(4) of such Act is amended by adding at the end the following: “Each participating physician directory for an area shall provide an alphabetical listing of all participating physicians practicing in the area and an alphabetical listing by locality and specialty of such physicians.”.

(3) EFFECTIVE DATES.—The amendments made by this paragraph shall first apply to directories for 1987.

(c) PROHIBITING UNASSIGNED BILLING OF SERVICES DETERMINED TO BE MEDICALLY UNNECESSARY BY A CARRIER.—

(1) IN GENERAL.—Section 1842 of the Social Security Act is further amended by adding at the end the following new subsection:

“(1)(A) Subject to subparagraph (C), if—

42 USC 1395u
note.
Contracts.

Hospitals.

42 USC 1395u
note.

“(i) a nonparticipating physician furnishes services to an individual enrolled for benefits under this part,

“(ii) payment for such services is not accepted on an assignment-related basis,

“(iii) a carrier determines under this part or a peer review organization determines under part B of title XI that payment may not be made by reason of section 1862(a)(1) because a service otherwise covered under this title is not reasonable and necessary under the standards described in that section, and

“(iv) the physician has collected any amounts for such services,

the physician shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts so collected.

“(B) A refund under subparagraph (A) is considered to be on a timely basis only if—

“(i) in the case of a physician who does not request reconsideration or seek appeal on a timely basis, the refund is made within 30 days after the date the physician receives a denial notice under paragraph (2), or

“(ii) in the case in which such a reconsideration or appeal is taken, the refund is made within 15 days after the date the physician receives notice of an adverse determination on reconsideration or appeal.

“(C) Subparagraph (A) shall not apply to the furnishing of a service by a physician to an individual if—

“(i) the physician did not know and could not reasonably have been expected to know that payment may not be made for the service by reason of section 1862(a)(1), or

“(ii) before the service was provided, the individual was informed that payment under this part may not be made for the specific service and the individual has agreed to pay for that service.

Contracts.

“(2) Each carrier with a contract in effect under this section with respect to physicians and each peer review organization with a contract under part B of title XI shall send any notice of denial of payment for physicians' services based on section 1862(a)(1) and for which payment is not requested on an assignment-related basis to the physician and the individual involved.

Sanctions.

“(3) If a physician knowingly and willfully fails to make refunds in violation of paragraph (1)(A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).”

42 USC 1395u
note.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 1987.

42 USC 1395u.

(d) DISCLOSURE OF INFORMATION OF UNASSIGNED CLAIMS FOR CERTAIN PHYSICIANS' SERVICES.—

(1) IN GENERAL.—Section 1842 of the Social Security Act, as amended by subsection (c)(1), is further amended by adding at the end the following new subsection:

“(m)(1) In the case of a nonparticipating physician who—

“(A) performs an elective surgical procedure for an individual enrolled for benefits under this part and for which the physician's actual charge is at least \$500, and

“(B) does not accept payment for such procedure on an assignment-related basis,

the physician must disclose to the individual, in writing and in a form approved by the Secretary, the physician's estimated actual charge for the procedure, the estimated approved charge under this

part for the procedure, the excess of the physician's actual charge over the approved charge, and the coinsurance amount applicable to the procedure. The written estimate may not be used as the basis for, or evidence in, a civil suit.

"(2) A physician who fails to make a disclosure required under paragraph (1) with respect to a procedure shall refund on a timely basis to the individual (and shall be liable to the individual for) any amounts collected for the procedure in excess of the charges recognized and approved under this part.

"(3) If a physician knowingly and willfully fails to comply with paragraph (2), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

Sanctions.

"(4) The Secretary shall provide for such monitoring of requests for payment for physicians' services to which paragraph (1) applies as is necessary to assure compliance with paragraph (2)."

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to surgical procedures performed on or after October 1, 1987.

42 USC 1395u note.

(e) **MAINTENANCE AND USE OF PARTICIPATING PHYSICIAN DIRECTORIES BY HOSPITALS.**—

42 USC 1395cc.

(1) **REQUIREMENT OF PARTICIPATION.**—Section 1866(a)(1) of the Social Security Act, as amended by section 9305(b)(1), is further amended—

Ante, p. 1989.

(A) by striking "and" at the end of subparagraph (L),

(B) by striking the period at the end of subparagraph (M) and inserting ", and", and

(C) by inserting after subparagraph (M) the following new subparagraph:

"(N) in the case of hospitals—

"(i) to make available to its patients the directory or directories of participating physicians (published under section 1842(h)(4)) for the area served by the hospital, and

"(ii) if hospital personnel (including staff of any emergency or outpatient department) refer a patient to a nonparticipating physician for further medical care on an outpatient basis, the personnel must inform the patient that the physician is a nonparticipating physician and, whenever practicable, must identify at least one qualified participating physician who is listed in such a directory and from whom the patient may receive the necessary services."

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to agreements under section 1866(a) of the Social Security Act as of October 1, 1987.

42 USC 1395cc note.

SEC. 9333. LIMITS ON REASONABLE CHARGES.

(a) **PROCEDURES FOR ESTABLISHMENT OF SPECIAL LIMITS ON REASONABLE CHARGES FOR PART B SERVICES.**—Section 1842(b)(8) of the Social Security Act (42 U.S.C. 1395u(b)(8)) is amended—

(1) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively;

(2) by inserting "(A)" after "(8)"; and

(3) by adding at the end the following new subparagraphs:

"(B)(i) The Secretary may provide for an increase or decrease in the reasonable charge otherwise recognized under this section with respect to a specific physicians' service only in accordance with the

Physicians.

criteria set forth in subparagraph (A) and with the succeeding provisions of this paragraph.

“(ii) The factors described pursuant to subparagraph (A)(i) with respect to payment for physicians’ services shall include, but need not be limited to, the following:

“(I) Prevailing charges for a service in a particular locality are significantly in excess of or below prevailing charges in other comparable localities, taking into account the relative costs of furnishing the services in the different localities.

“(II) The programs established under this title and title XIX are the sole or primary sources of payment for a service.

“(III) The marketplace for a service is not truly competitive because of a limited number of physicians who perform that service.

“(IV) There have been increases in charges for a service that cannot be explained by inflation or technology.

“(V) The charges do not reflect changing technology, increased facility with that technology, or reductions in acquisition or production costs.

“(VI) The prevailing charges for a service under this part are substantially higher or lower than the payments made for the service by other purchasers in the same locality.

“(iii) In applying subparagraph (A), the Secretary may compare—

“(I) the charges and resource costs for related procedures,

“(II) charges and resource costs for the procedure over a period of time,

“(III) charges for a procedure in different geographic areas, and

“(IV) the charges and allowed payments for a procedure under this part and by other payors.

“(iv) The factors considered under subparagraph (A)(ii) shall take into account regional differences in fees, unless there is substantial economic justification for a uniform fee or a uniform payment limit. Such substantial economic justification must be explained by the Secretary in the notice and final determination required by paragraph (9).

“(v) An adjustment under clause (i) on the basis of a comparison of the prevailing charges in different localities may be made only if the Secretary determines that the prevailing charge allowed in one locality is out of line with prevailing charges allowed in other localities after accounting for differences in practice costs.

“(vi) In this subparagraph, ‘resource costs’ include factors such as the time required to provide a procedure (including pre-procedure evaluation and post-procedure follow-up), the complexity of the procedure, the training required to perform the procedure, and the risk involved in the procedure.

Claims.

“(C) In determining whether to adjust payment rates under subparagraph (B)(i), the Secretary shall consider the potential impacts on quality, access, and beneficiary liability of the adjustment, including the likely effects on assignment rates, reasonable charge reductions on unassigned claims, and participation rates of physicians.”.

Post, p. 2035.

(b) INHERENT REASONABLENESS PROCEDURES.—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended by redesignating paragraph (9) as paragraph (11) and inserting after paragraph (8) the following new paragraphs:

“(9)(A) In the case of any physicians’ service with respect to which the Secretary—

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“(i) determines, after appropriate consultation with representatives of the physicians likely to be affected by any change in the reasonable charge, that the application of this subsection results in the determination of a reasonable charge that, by reason of its grossly excessive or grossly deficient amount, is not inherently reasonable, and

“(ii) proposes to establish a reasonable charge that is realistic and equitable or a methodology for arriving at such a charge, the Secretary shall publish notice of such proposal in the Federal Register.

Federal
Register,
publication.

“(B) A notice required by subparagraph (A) shall—

“(i) specify the charge or methodology proposed to be established with respect to a service and shall explain the factors and data that the Secretary took into account in determining the charge or methodology so specified, and

“(ii) explain the potential impacts described in paragraph (8)(C).

“(C) After publication of the notice required by subparagraph (A), the Secretary shall allow not less than 60 days for public comment on the proposal.

“(D) In addition to carrying out its functions under section 1845, the Physician Payment Review Commission (in this paragraph referred to as the ‘Commission’) shall comment on any such proposal within the period of comment allowed by the Secretary pursuant to subparagraph (C).

Ante, p. 190.

“(E)(i) Taking into consideration the comments made by the Commission and the public, the Secretary shall publish in the Federal Register a final determination with respect to the reasonable charge or methodology to be established with respect to the service.

Federal
Register,
publication.

“(ii) A final determination published pursuant to clause (i) shall explain the factors and data that the Secretary took into consideration in making the final determination, and shall include and respond to the comments made by the Commission pursuant to subparagraph (D).

“(10)(A)(i) If an adjustment under paragraph (8)(B) results in a reduction in the reasonable charge for a physicians’ service, and a nonparticipating physician furnishes the service to an individual entitled to benefits under this part after the effective date of such reduction and before the end of the period described in subparagraph (C), the physician may not charge the individual more than the limiting charge (as defined in clause (ii)) plus (for services furnished during the 12-month period beginning on the effective date of the reduction) $\frac{1}{2}$ of the amount by which the physician’s actual charge for the service for the previous 12-month period exceeds the limiting charge.

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“(ii) In clause (i), the term ‘limiting charge’ means, with respect to a service, 125 percent of the inherently reasonable charge established under paragraph (8).

“(B) If a physician knowingly and willfully imposes charges in violation of subparagraph (A), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

Sanctions.

“(C) Subparagraph (A) shall not apply to services furnished after the earlier of (i) December 31, 1990, or (ii) one-year after the date the

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Ante, p. 192.

Secretary reports to Congress, under section 1845(e)(3), on the development of the relative value scale under section 1845.”

42 USC 1395u
note.

(c) **REVIEW OF PROCEDURES.**—Not later than October 1, 1987, the Secretary of Health and Human Services shall review the inherent reasonableness of the reasonable charges for at least 10 of the most costly procedures with respect to which payment is made under part B of title XVIII of the Social Security Act (determined on the basis of the aggregate annual payments under such part with respect to each such procedure).

42 USC 1395u
note.

(d) **EFFECTIVE DATE.**—The amendments made by this section shall take effect on the date of the enactment of this Act.

SEC. 9334. PAYMENT FOR CATARACT SURGICAL PROCEDURES.

(a) **LIMITATIONS.**—Section 1842(b)(11) of the Social Security Act (42 U.S.C. 1395u(b)(11)), as redesignated by section 9333(b), is amended—

(1) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively,

(2) by inserting “(A)” after “(11)”, and

(3) by adding at the end the following new subparagraphs:

“(B)(i) In determining the reasonable charge under paragraph (3) for a cataract surgical procedure, subject to clause (ii), the prevailing charge for such procedure otherwise recognized for participating and nonparticipating physicians shall be reduced by 10 percent with respect to procedures performed in 1987 and shall be further reduced by 2 percent with respect to procedures performed in 1988. A reduced prevailing charge under this subparagraph shall become the prevailing charge level for subsequent years for purposes of applying the economic index under the fourth sentence of paragraph (3).

“(ii) In no case shall the reduction under clause (i) for a surgical procedure result in a prevailing charge in a locality for a year which is less than 75 percent of the weighted national average of such prevailing charges for such procedure for all the localities in the United States for 1986.

“(C)(i) In the case of a reduction in the reasonable charge for a physicians’ service under subparagraph (B), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part after the effective date of such reduction (subject to clause (iv)), the physician may not charge the individual more than the limiting charge (as defined in clause (ii)) plus (for services furnished during the 12-month period beginning on the effective date of the reduction) ½ of the amount by which the physician’s actual charges for the service for the previous 12-month period exceeds the limiting charge.

“(ii) In clause (i), the term ‘limiting charge’ means, with respect to a service, 125 percent of the prevailing charge for the service after the reduction referred to in clause (i).

Sanctions.

“(iii) If a physician knowingly and willfully imposes charges in violation of clause (i), the Secretary may apply sanctions against such physician in accordance with subsection (j)(2).

“(iv) This subparagraph shall not apply to services furnished after the earlier of (I) December 31, 1990, or (II) one-year after the date the Secretary reports to Congress, under section 1845(e)(3), on the development of the relative value scale under section 1845.”

(b) **RATIFICATION OF REGULATIONS.**—

(1) **IN GENERAL.**—The Congress hereby ratifies the final regulation of the Secretary of Health and Human Services published

42 USC 1395u
note.

on page 35693 of volume 51 of the Federal Register on October 7, 1986, relating to reasonable charge payment limits for anesthesia services under the medicare program.

(2) **PATIENT PROTECTIONS.**—In the case of any reduction in the reasonable charge for physicians' services effected under the regulation described in paragraph (1), the provisions of section 1842(b)(10) of the Social Security Act (added by the amendment made by subsection (a)(3)) shall apply in the same manner and to the same extent as they apply to a reduction in the reasonable charge for a physicians' service effected under section 1842(b)(8) of such Act.

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished on or after January 1, 1987.

SEC. 9335. PAYMENT RATES FOR RENAL SERVICES AND IMPROVEMENTS IN ADMINISTRATION OF END STAGE RENAL DISEASE NETWORKS AND PROGRAM.

(a) **COMPOSITE RATES FOR DIALYSIS SERVICES.**—

(1) **IN GENERAL.**—Effective with respect to dialysis services provided on or after October 1, 1986, and before October 1, 1988, the Secretary of Health and Human Services shall establish the base rate for routine dialysis treatment in a free-standing facility and in a hospital-based facility under section 1881(b)(7) of the Social Security Act at a level equal to the respective rate in effect as of May 13, 1986, reduced by \$2.00.

(2) **ASSURING PROMPT CONSIDERATION OF EXCEPTION REQUESTS.**—Section 1881(b)(7) of the Social Security Act (42 U.S.C. 1395rr(b)(7)) is amended—

(A) in the third sentence, by inserting “and of pediatric facilities” after “isolated, rural areas”, and

(B) by inserting after the third sentence the following new sentence: “Each application for such an exception shall be deemed to be approved unless the Secretary disapproves it by not later than 60 working days after the date the application is filed.”

(3) **EFFECTIVE DATE.**—The amendments made by paragraph (2) shall apply to applications filed on or after the date of the enactment of this Act.

(b) **REPORT ON PAYMENT RATES.**—

(1) **IN GENERAL.**—The Secretary of Health and Human Services shall provide for—

(A) a study to evaluate the effects of reductions in the rates of payment for facility and physicians' services under the medicare program for patients with end stage renal disease on their access to care or on the quality of care, and

(B) a report to Congress on the results of the study by not later than January 1, 1988.

(2) **ARRANGEMENTS WITH INSTITUTE OF MEDICINE.**—The Secretary shall request the National Academy of Sciences, acting through appropriate units, to submit an application to conduct the study described in paragraph (1). If the Academy submits an acceptable application, the Secretary shall enter into an appropriate arrangement with the Academy for the conduct of the study. If the Academy does not submit an acceptable application to conduct the study, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an appropriate

Physicians.

42 USC 1395u.

42 USC 1395u
note.

42 USC 1395rr
note.

42 USC 1395rr.

42 USC 1395rr
note.

42 USC 1395rr
note.

Physicians.

Reports.

arrangement for the conduct of the study by the entity which submits the best acceptable application.

(c) COVERAGE OF IMMUNOSUPPRESSIVE DRUGS.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) by striking “and” at the end of subparagraph (H)(ii),

(B) by inserting “and” at the end of subparagraph (I), and

(C) by inserting after subparagraph (I) the following new subparagraph:

“(J) immunosuppressive drugs furnished, to an individual who receives an organ transplant for which payment is made under this title, within 1 year after the date of the transplant procedure;”.

42 USC 1395x
note.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to immunosuppressive drugs furnished on or after January 1, 1987.

(d) REORGANIZATION OF ESRD NETWORK AREAS AND ORGANIZATIONS.—

(1) IN GENERAL.—Subparagraph (A) of subsection (c)(1) of section 1881 of the Social Security Act (42 U.S.C. 1395rr) is amended to read as follows:

“(A)(i) For the purpose of assuring effective and efficient administration of the benefits provided under this section, the Secretary shall, in accordance with such criteria as he finds necessary to assure the performance of the responsibilities and functions specified in paragraph (2)—

“(I) establish at least 17 end stage renal disease network areas, and

Physicians.
Nurses.

“(II) for each such area, designate a network administrative organization which, in accordance with regulations of the Secretary, shall establish (aa) a network council of renal dialysis and transplant facilities located in the area and (bb) a medical review board, which has a membership including at least one patient representative and physicians, nurses, and social workers engaged in treatment relating to end stage renal disease.

Federal
Register,
publication.

The Secretary shall publish in the Federal Register a description of the geographic area that he determines, after consultation with appropriate professional and patient organizations, constitutes each network area and the criteria on the basis of which such determination is made.

Federal
Register,
publication.

“(ii)(I) In order to determine whether the Secretary should enter into, continue, or terminate an agreement with a network administrative organization designated for an area established under clause (i), the Secretary shall develop and publish in the Federal Register standards, criteria, and procedures to evaluate an applicant organization's capabilities to perform (and, in the case of an organization with which such an agreement is in effect, actual performance of) the responsibilities described in paragraph (2). The Secretary shall evaluate each applicant based on quality and scope of services and may not accord more than 20 percent of the weight of the evaluation to the element of price.

“(II) An agreement with a network administrative organization may be terminated by the Secretary only if he finds, after applying such standards and criteria, that the organization has failed to perform its prescribed responsibilities effectively and efficiently. If such an agreement is to be terminated, the Secretary shall select a

successor to the agreement on the basis of competitive bidding and in a manner that provides an orderly transition.”

(2) **DEADLINE FOR ESTABLISHING NEW AREAS.**—The Secretary of Health and Human Services shall establish end stage renal disease network areas, pursuant to the amendment made by paragraph (1), not later than May 1, 1987. The Secretary shall establish network administrative organizations for such areas by not later than July 1, 1987.

42 USC 1395rr
note.

(3) **TRANSITION.**—If, under the amendment made by paragraph (1), the Secretary designates a network administrative organization for an area which was not previously designated for that area, the Secretary shall offer to continue to fund the previously designated organization for that area for a period of 30 days after the first date the newly designated organization assumes the duties of a network administrative organization for that area.

42 USC 1395rr
note.

(e) **PATIENT REPRESENTATION ON COUNCILS AND MEDICAL REVIEW BOARDS.**—Subparagraph (B) of subsection (c)(1) of section 1881 of the Social Security Act is amended to read as follows:

42 USC 1395rr.

“(B) At least one patient representative shall serve as a member of each network council and each medical review board.”

(f) **RESPONSIBILITIES OF NETWORK ORGANIZATIONS.**—Subsection (c)(2) of section 1881 of such Act is amended—

(1) in subparagraph (A), by inserting before the semicolon the following: “and the participation of patients, providers of services, and renal disease facilities in vocational rehabilitation programs”;

(2) in subparagraph (B), by inserting before the first semicolon the following: “and with respect to working with patients, facilities, and providers in encouraging participation in vocational rehabilitation programs”;

(3) in subparagraph (D), by inserting before the semicolon the following: “and reporting to the Secretary on facilities and providers that are not providing appropriate medical care”;

(4) in subparagraph (E), by inserting “and encouraging participation in vocational rehabilitation programs” after “self-care settings and transplantation”; and

(5) by redesignating subparagraphs (D) and (E) as subparagraphs (G) and (H), respectively, and inserting after subparagraph (C) the following new subparagraphs:

“(D) implementing a procedure for evaluating and resolving patient grievances;

“(E) conducting on-site reviews of facilities and providers as necessary (as determined by a medical review board or the Secretary), utilizing standards of care established by the network organization to assure proper medical care;

“(F) collecting, validating, and analyzing such data as are necessary to prepare the reports required by subparagraph (H) and subsection (g) and to assure the maintenance of the registry established under paragraph (7);”

Reports.

(g) **FACILITY COOPERATION WITH NETWORKS.**—The first sentence of subsection (c)(3) of section 1881 of such Act is amended by inserting “or to follow the recommendations of the medical review board” after “consistently failed to cooperate with network plans and goals”.

(h) **INTENT OF CONGRESS RESPECTING MAXIMUM USE OF VOCATIONAL REHABILITATION SERVICES.**—The first sentence of subsection

42 USC 1395rr. (c)(6) of section 1881 of such Act is amended by inserting before the period the following: "and that the maximum practical number of patients who are suitable candidates for vocational rehabilitation services be given access to such services and encouraged to return to gainful employment".

42 USC 1395rr. (i) NATIONAL END STAGE RENAL DISEASE REGISTRY.—

(1) ESTABLISHMENT OF REGISTRY.—Subsection (c) of section 1881 of such Act is further amended by adding at the end the following new paragraph:

"(7) The Secretary shall establish a national end stage renal disease registry the purpose of which shall be to assemble and analyze the data reported by network organizations, transplant centers, and other sources on all end stage renal disease patients in a manner that will permit—

Reports. "(A) the preparation of the annual report to the Congress required under subsection (g);

"(B) an identification of the economic impact, cost-effectiveness, and medical efficacy of alternative modalities of treatment;

Research and development. "(C) an evaluation with respect to the most appropriate allocation of resources for the treatment and research into the cause of end stage renal disease;

"(D) the determination of patient mortality and morbidity rates, and trends in such rates, and other indices of quality of care; and

"(E) such other analyses relating to the treatment and management of end stage renal disease as will assist the Congress in evaluating the end stage renal disease program under this section.

The Secretary shall provide for such coordination of data collection activities, and such consolidation of existing end stage renal disease data systems, as is necessary to achieve the purpose of such registry, shall determine the appropriate location of the registry, and shall provide for the appointment of a professional advisory group to assist the Secretary in the formulation of policies and procedures relevant to the management of such registry."

42 USC 1395rr note. (2) REPORT.—The Secretary of Health and Human Services shall submit to the Congress, no later than April 1, 1987, a full report on the progress made in establishing the national end stage renal disease registry under the amendment made by paragraph (1) and shall establish such registry by not later than January 1, 1988.

(j) FUNDING OF ESRD NETWORK ORGANIZATIONS.—

(1) IN GENERAL.—Subsection (b)(7) of section 1881 of the Social Security Act is amended by adding at the end the following new sentence: "The Secretary shall reduce the amount of each composite rate payment under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the network administrative organization (designated under subsection (c)(1)(A) for the network area in which the treatment is provided) for its necessary and proper administrative costs incurred in carrying out its responsibilities under subsection (c)(2)."

42 USC 1395rr note. (2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to treatment furnished on or after January 1, 1987.

(k) PROTOCOLS ON REUSE OF DIALYSIS FILTERS AND OTHER DIALYSIS SUPPLIES.—

(1) **ESTABLISHMENT OF PROTOCOLS.**—Paragraph (7) of subsection (f) of section 1881 of the Social Security Act is amended to read as follows: 42 USC 1395rr

“(7)(A) The Secretary shall establish protocols on standards and conditions for the reuse of dialyzer filters for those facilities and providers which voluntarily elect to reuse such filters.

“(B) With respect to dialysis services furnished on or after January 1, 1988, no dialysis facility may reuse dialysis supplies (other than dialyzer filters) unless the Secretary has established a protocol with respect to the reuse of such supplies and the facility follows the protocol so established.

“(C) The Secretary shall incorporate protocols established under this paragraph, and the requirement of subparagraph (B), into the requirements for facilities prescribed under subsection (b)(1)(A) and failure to follow such a protocol or requirement subjects such a facility to denial of participation in the program established under this section and to denial of payment for dialysis treatment not furnished in compliance with such a protocol or in violation of such requirement.”.

(2) **DEADLINE.**—The Secretary of Health and Human Services shall establish the protocols described in section 1881(f)(7)(A) of the Social Security Act by not later than October 1, 1987. 42 USC 1395rr note.

(l) **EFFECTIVE DATE FOR CERTAIN AMENDMENTS.**—The amendments made by subsections (e), (f), and (g) shall apply to network administrative organizations designated for network areas established under the amendment made by subsection (d)(1). 42 USC 1395rr note.

SEC. 9336. VISION CARE.

(a) **DEFINING SERVICES AN OPTOMETRIST CAN PROVIDE.**—Clause (4) of section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)) is amended to read as follows: “(4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or”.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall apply to services furnished on or after April 1, 1987. 42 USC 1395x note.

SEC. 9337. OCCUPATIONAL THERAPY SERVICES.

(a) **COVERAGE.**—Subparagraph (C) of section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)) is amended to read as follows:

“(C) outpatient physical therapy services (other than services to which the second sentence of section 1861(p) applies) and outpatient occupational therapy services (other than services to which such sentence applies through the operation of section 1861(g)).”.

(b) **LIMITATION ON PAYMENTS.**—Section 1833(g) of such Act (42 U.S.C. 1395l(g)) is amended—

(1) by striking “next to last sentence” and inserting “second sentence”, and

(2) by adding at the end thereof the following new sentence: “In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than \$500 shall be consid-

ered as incurred expenses for purposes of subsections (a) and (b)."

(c) **CERTIFICATION STANDARD.**—(1) Section 1835(a)(2)(C) of such Act (42 U.S.C. 1395n(a)(2)(C)) is amended—

(A) by inserting "or outpatient occupational therapy services" after "outpatient physical therapy services",

(B) in clause (i), by inserting "or occupational therapy services, respectively," after "physical therapy services", and

(C) in clause (ii), by inserting "or qualified occupational therapist, respectively," after "qualified physical therapist".

(2) The second sentence of section 1835(a) of such Act and section 1866(e) of such Act (42 U.S.C. 1395n(a), 1395cc(e)) are each amended—

(A) by inserting "(or meets the requirements of such section through the operation of section 1861(g))" after "1861(p)(4)(A)" and after "1861(p)(4)(B)", and

(B) by inserting "or (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services" after "(as therein defined)".

(d) **DEFINITION AND INCLUSION WITH OTHER PART B SERVICES.**—(1) Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by inserting after subsection (f) the following new subsection:

"OUTPATIENT OCCUPATIONAL THERAPY SERVICES

"(g) The term 'outpatient occupational therapy services' has the meaning given the term 'outpatient physical therapy services' in subsection (p), except that 'occupational' shall be substituted for 'physical' each place it appears therein."

(2) Section 1861(s)(2)(D) of such Act (42 U.S.C. 1395x(s)(2)(D)) is amended by inserting "and outpatient occupational therapy services" after "outpatient physical therapy services".

(3) Section 1861(v)(5)(A) of such Act (42 U.S.C. 1395x(v)(5)(A)) is amended by inserting "(including through the operation of section 1861(g))" after "section 1861(p)".

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply to expenses incurred for outpatient occupational therapy services furnished on or after July 1, 1987.

SEC. 9338. SERVICES OF A PHYSICIAN ASSISTANT.

(a) **SERVICES COVERED.**—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 9335(c)(1) of this subtitle, is amended—

(1) by striking "and" at the end of subparagraph (I),

(2) by adding "and" at the end of subparagraph (J), and

(3) by adding at the end the following new subparagraph:

"(K)(i) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a physician assistant (as defined in subsection (aa)(3)) under the supervision of a physician (as so defined) in a hospital, skilled nursing facility, or intermediate care facility (as defined in section 1905(c)) or as an assistant at surgery and which the physician assistant is legally authorized to perform by the State in which the services are performed, and

"(ii) such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished as an incident to a physician's professional service;"

42 USC 1395k
note.

42 USC 1396d.

(b) **DETERMINATION OF PAYMENT AMOUNT.**—Section 1842(b) of such Act (42 U.S.C. 1395u(b)), as amended by section 9333(b), is amended by adding at the end the following new paragraph:

“(12)(A) With respect to services described in section 1861(s)(2)(K) (relating to a physician assistant acting under the supervision of a physician)— 42 USC 1395x.

“(i) payment under this part may only be made on an assignment-related basis; and

(ii) the prevailing charges determined under paragraph (3) shall not exceed—

“(I) in the case of services performed as an assistant at surgery, 65 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, or

“(II) in other cases, the applicable percentage (as defined in subparagraph (B)) of the prevailing charge rate determined for such services performed by physicians who are not specialists.

“(B) In subparagraph (A)(ii)(II), the term ‘applicable percentage’ means—

“(i) 75 percent in the case of services performed (other than as an assistant at surgery) in a hospital, and

“(ii) 85 percent in the case of other services.

“(C) Except for deductible and coinsurance amounts applicable under section 1833, any person who knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in section 1861(s)(2)(K) in violation of subparagraph (A)(i) is subject to a civil monetary penalty of not to exceed \$2,000 for each such bill or request. Such a penalty shall be imposed in the same manner as civil monetary penalties are imposed under section 1128A with respect to actions described in subsection (a) of that section.”

Ante, p. 2014.

Ante, pp. 2003, 2008.

(c) **PAYMENT TO EMPLOYER.**—The first sentence of section 1842(b)(6) of such Act (42 U.S.C. 1395u(b)(6)) is amended—

(1) by striking “except that payment may be made (A)(i)” and inserting “except that (A) payment may be made (i)”;

(2) by striking “or (B)” and by inserting “(B) payment may be made”; and

(3) by inserting before the period at the end the following: “, and (C) in the case of services described in section 1861(s)(2)(K) payment shall be made to the employer of the physician assistant involved”.

(d) **REDUCTION IN PAYMENT TO AVOID DUPLICATE PAYMENT.**—Notwithstanding any other provision of law, the Secretary of Health and Human Services may reduce the amount of payments otherwise made to hospitals and skilled nursing facilities under title XVIII of the Social Security Act, so as to eliminate estimated duplicate payments for historical or current costs attributable to services described in section 1861(s)(2)(K) of such Act (for which payment may be made under the amendments made by this section).

Hospitals.
42 USC 1395x
note.

42 USC 1395.

(e) **STUDY OF PAYMENT RATES.**—The Secretary shall report to Congress, by not later than April 1, 1988, concerning adjustments to the amount of payment made, under part B of title XVIII of the Social Security Act, for services described in section 1861(s)(2)(K) of such Act, to ensure that the amount of such payments reflects the approximate cost of furnishing the services, taking into account

Reports.
42 USC 1395x
note.

42 USC 1395j.

compensation costs and overhead and supervision costs attributable to physician assistants.

42 USC 1395x
note.

(f) **EFFECTIVE DATE.**—The amendments made by this section shall apply to services furnished on or after January 1, 1987.

SEC. 9339. PAYMENT FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) TREATMENT OF HOSPITAL OUTPATIENT LABORATORIES.—

(1) **IN GENERAL.**—Section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) is amended—

(A) in paragraph (1)(B), by striking “hospital laboratory” and inserting “qualified hospital laboratory (as defined in subparagraph (D))”,

(B) in paragraph (1)(C)—

(i) in the first sentence, by striking “hospital laboratory” and inserting “qualified hospital laboratory (as defined in subparagraph (D))”, and by striking “, and ending on December 31, 1987”, and

(ii) by striking the second sentence;

(C) by adding at the end of paragraph (1) the following new subparagraph:

“(D) In this subsection, the term ‘qualified hospital laboratory’ means a hospital laboratory which provides some clinical diagnostic laboratory tests 24 hours a day in order to serve a hospital emergency room which is available to provide services 24 hours a day and 7 days a week.”; and

(D) in paragraph (2), by striking “hospital laboratory” and inserting “qualified hospital laboratory (as defined in paragraph (1)(D))”.

42 USC 1395l
note.

(2) **EFFECTIVE DATE.**—The amendments made by this subsection apply to clinical diagnostic laboratory tests performed on or after January 1, 1987.

(b) DELAYING FOR 2 YEARS REQUIREMENT OF NATIONAL FEE SCHEDULE.—

(1) **IN GENERAL.**—Section 1833(h)(1)(B) of such Act is amended by striking “1987” and “1988” and inserting “1989” and “1990”, respectively.

(2) **CONFORMING AMENDMENT.**—Section 1833(h)(2) of such Act is amended by striking “(or, effective January 1, 1988, for the United States)”.

42 USC 1395l
note.

(3) **REPORT.**—The Secretary of Health and Human Services shall report to Congress, by not later than April 1, 1988, on the advisability and feasibility of, and methodology for, establishing national fee schedules for payment for clinical diagnostic laboratory tests under section 1833(h) of the Social Security Act.

(c) PAYMENT FOR TIME AND TRAVEL COSTS TO COLLECT SAMPLES FROM CERTAIN IMMOBILE BENEFICIARIES.—

(1) **IN GENERAL.**—Section 1833(h)(3) of such Act is amended—

(A) by inserting “(A)” after “provide for and establish”, and

(B) by inserting before the period at the end the following: “, and (B) a fee to cover the transportation and personnel expenses for trained personnel to travel to the location of an individual to collect the sample, except that such a fee may be provided only with respect to an individual who is homebound or an inpatient in an inpatient facility (other than a hospital)”.

(2) **EFFECTIVE DATE.**—The amendment made by paragraph (1) shall apply to samples collected on or after January 1, 1987. 42 USC 1395l note.

(d) **STATE STANDARDS FOR DIRECTORS OF CLINICAL LABORATORIES.**— 42 USC 1395l note.

(1) **IN GENERAL.**—If a State (as defined for purposes of title XVIII of the Social Security Act) provides for the licensing or other standards with respect to the operation of clinical laboratories (including such laboratories in hospitals) in the State under which such a laboratory may be directed by an individual with certain qualifications, nothing in such title shall be construed as authorizing the Secretary of Health and Human Services to require such a laboratory, as a condition of payment or participation under such title, to be directed by an individual with other qualifications. 42 USC 1395.

(2) **EFFECTIVE DATE.**—Paragraph (1) shall take effect on January 1, 1987.

(e) **EXTENSION OF MORATORIUM ON LABORATORY PAYMENT DEMONSTRATION.**—Section 9204(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking “January 1, 1987” and inserting “January 1, 1988”. 42 USC 1395ww note. Ante, p. 177.

SEC. 9340. PAYMENT FOR PARENTERAL AND ENTERAL NUTRITION SUPPLIES AND EQUIPMENT.

The Secretary of Health and Human Services shall apply the sixth sentence of section 1842(b)(3) of the Social Security Act to payment—

(1) for enteral nutrition nutrients, supplies, and equipment and parenteral nutrition supplies and equipment furnished on or after January 1, 1987, and

(2) for parenteral nutrition nutrients furnished on or after October 1, 1987.

42 USC 1395u note.

SEC. 9341. CHANGING MEDICARE APPEAL RIGHTS.

(a) **REVIEW OF PART B DETERMINATIONS.**—(1) Section 1869 of the Social Security Act (42 U.S.C. 1395ff) is amended—

(A) by inserting “or part B” in subsection (a) after “amount of benefits under part A”,

(B) by inserting “or part B” in subsection (b)(1)(C) after “part A”,

(C) by amending paragraph (2) of subsection (b) to read as follows:

“(2) Notwithstanding paragraph (1)(C), in the case of a claim arising—

“(A) under part A, a hearing shall not be available to an individual under paragraph (1)(C) if the amount in controversy is less than \$100 and judicial review shall not be available to the individual under that paragraph if the amount in controversy is less than \$1,000; or

“(B) under part B, a hearing shall not be available to an individual under paragraph (1)(C) if the amount in controversy is less than \$500 and judicial review shall not be available to the individual under that paragraph if the aggregate amount in controversy is less than \$1,000.

In determining the amount in controversy, the Secretary, under regulations, shall allow two or more claims to be aggregated if the claims involve the delivery of similar or related services to the same individual or involve common issues of law and fact arising from services furnished to two or more individuals.”, and

Regulations.
Claims.

(D) by adding at the end the following new paragraphs:
 “(3) Review of any national coverage determination under section 1862(a)(1) respecting whether or not a particular type or class of items or services is covered under this title shall be subject to the following limitations:

“(A) Such a determination shall not be reviewed by any administrative law judge.

“(B) Such a determination shall not be held unlawful or set aside on the ground that a requirement of chapter 5 of title 5, United States Code, or section 1871(b), relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

“(C) In any case in which a court determines that the record is incomplete or otherwise lacks adequate information to support the validity of the determination, it shall remand the matter to the Secretary for additional proceedings to supplement the record and the court may not determine that an item or service is covered except upon review of the supplemented record.

“(4) A regulation or instruction which relates to a method for determining the amount of payment under part B and which was initially issued before January 1, 1981, shall not be subject to judicial review.”.

(2) Section 1842(b)(3)(C) of such Act (42 U.S.C. 1395u(b)(3)(C)) is amended by striking “\$100 or more” and inserting “at least \$100, but not more than \$500”.

(3) Section 1879(d) of such Act (42 U.S.C. 1395pp(d)) is amended by striking “section 1869(b)” and all that follows through “part B)” and inserting “sections 1869(b) and 1842(b)(3)(C) (as may be applicable)”.

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply to items and services furnished on or after January 1, 1987.

SEC. 9342. ALZHEIMER'S DISEASE DEMONSTRATION PROJECTS.

(a) **DEMONSTRATION PROJECTS.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) shall conduct at least 5 (and not more than 10) demonstration projects to determine the effectiveness, cost, and impact on health status and functioning of providing comprehensive services for individuals entitled to benefits under title XVIII of the Social Security Act (in this section referred to as “medicare beneficiaries”) who are victims of Alzheimer's disease or related disorders.

(b) **SERVICES UNDER DEMONSTRATION PROJECTS.**—The services provided under demonstration projects must be designed to meet the specific needs of Alzheimer's disease patients and may include—

- (1) case management services,
- (2) home and community-based services,
- (3) mental health services,
- (4) outpatient drug therapy,
- (5) respite care and other supportive services and counseling for family,
- (6) adult day care services, and
- (7) other in-home services.

(c) **CONDUCT OF PROJECTS.**—The demonstration projects shall—

- (1) each be conducted over a period of 3 years;
- (2) provide each medicare beneficiary with a comprehensive medical and mental status evaluation upon entering the project and at discharge;

42 USC 1395y.

5 USC 500 *et seq.*
ante, p. 2017.

Records.

42 USC 1395ff.
 42 USC 1395ff
 note.

42 USC 1395b-1
 note.

42 USC 1395.

(3) be conducted by an entity which either directly or by contract is able to provide such comprehensive evaluations and the additional services (described in subsection (b)) covered by the project;

Contracts.

(4) be conducted in sites which are chosen so as to be geographically diverse and located in States with a high proportion of medicare beneficiaries and in areas readily accessible to a significant number of medicare beneficiaries; and

State and local governments.

(5) involve community outreach efforts at each site to enroll the maximum number of medicare beneficiaries in each project.

(d) **EVALUATION AND REPORTS.**—The Secretary shall provide for an evaluation of the demonstration projects and shall submit to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate—

(1) a preliminary report during the third year of the projects, which report shall include a description of the sites at which the projects are being conducted and the services being provided at the different sites, and

(2) a final report upon completion of the projects, which report shall include recommendations for appropriate legislative changes.

(f) **FUNDING.**—Expenditures (not to exceed \$40,000,000 for the projects and \$2,000,000 for the evaluation of the projects) made for the demonstration projects shall be made from the Federal Supplementary Medical Insurance Trust Fund (established by section 1841 of the Social Security Act). Grants and payments under contracts may be made either in advance or by way of reimbursement, as may be determined by the Secretary, and shall be made in such installments and on such conditions as the Secretary finds necessary to carry out the purpose of this section.

Grants.
Contracts.

42 USC 1395t.

(g) **WAIVER OF MEDICARE REQUIREMENTS.**—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to the extent and for the period the Secretary finds necessary for the conduct of the demonstration projects.

42 USC 1395.

SEC. 9343. PAYMENTS FOR AMBULATORY SURGERY.

(a) AMOUNTS PAYABLE; ANNUAL UPDATING.—

(1)(A) Section 1833(a)(4) of the Social Security Act (42 U.S.C. 1395l(a)(4)) is amended to read as follows:

“(4) in the case of facility services described in section 1832(a)(2)(F), and outpatient hospital facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1)(A), the applicable amount as determined under paragraph (2) or (3) of subsection (i).”.

Hospitals.
42 USC 1395k.

(B) Section 1833(i) of such Act (42 U.S.C. 1395l(i)) is amended by redesignating paragraphs (3) and (4) as paragraphs (4) and (5), respectively, and inserting after paragraph (2) the following new paragraph:

“(3)(A) The aggregate amount of the payments to be made under this part for outpatient hospital facility services furnished in connection with surgical procedures specified under paragraph (1)(A) in a cost reporting period shall be equal to the lesser of—

Hospitals.

“(i) the amount determined with respect to such services under subsection (a)(2)(B); or

“(ii) the blend amount (described in subparagraph (B)).

“(B)(i) The blend amount for a cost reporting period is the sum of—

“(I) the cost proportion (as defined in clause (ii)(I) of the amount described in subparagraph (A)(i), and

“(II) the ASC proportion (as defined in clause (ii)(II) of 80 percent of the standard overhead amount payable with respect to the same surgical procedure as if it were provided in an ambulatory surgical center in the same area, as determined under paragraph (2)(A).

“(ii) In this paragraph:

“(I) The term ‘cost proportion’ means 75 percent for cost reporting periods beginning in fiscal year 1988, and 50 percent for other cost reporting periods.

“(II) The term ‘ASC proportion’ means 25 percent for cost reporting periods beginning in fiscal year 1988, and 50 percent for other cost reporting periods.”.

42 USC 1395f.

(2) CONFORMING AMENDMENT.—Section 1833(b)(3) of such Act is amended by striking “or (i)(4)” and inserting in lieu thereof “or (i)(5)”.

(b) UPDATING ASC RATES.—

(1) RATE UPDATE.—Subparagraphs (A) and (B) of section 1833(i)(2) of such Act are each amended by striking “shall be reviewed periodically” and inserting in lieu thereof “shall be reviewed and updated not later than July 1, 1987, and annually thereafter”.

(2) ASC LIST UPDATE.—Section 1833(i)(1) of such Act is amended by adding at the end (after and below subparagraph (B)) the following:

“The lists of procedures established under subparagraphs (A) and (B) shall be reviewed and updated not less often than every 2 years.”.

(c) PREVENTING UNBUNDLING OF HOSPITAL OUTPATIENT SERVICES.—

(1) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by striking “inpatient” and inserting “patient”.

(2) Section 1866(a)(1)(H) of such Act (42 U.S.C. 1395cc(a)(1)(H)) is amended—

(A) by striking “inpatient hospital”, and

(B) by striking “an inpatient” and inserting “a patient”.

(3) Section 1866 of such Act (42 U.S.C. 1395cc) is further amended by adding at the end the following new subsection:

Hospitals.

“(g) Except as permitted under subsection (a)(2), any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment for a hospital outpatient service for which payment may be made under part B and such bill or request violates an arrangement under subsection (a)(1)(H), is subject to a civil monetary penalty of not to exceed \$2,000. Such a penalty shall be imposed in the same manner as civil monetary penalties are imposed under section 1128A with respect to actions described in subsection (a) of that section.”.

Ante, pp. 2003, 2008.

(d) PRO REVIEW.—

(1) Section 1154(a)(1) of the Social Security Act (42 U.S.C. 1320c-3(a)(1)) is amended by inserting “and subject to the requirements of subsection (d)” after “subject to the terms of the contract”.

(2) Section 1154 of such Act is amended by adding at the end the following new subsection:

“(d) Each contract under this part shall require that the utilization and quality control peer review organization’s review responsibility pursuant to subsection (a)(1) will include review of all ambulatory surgical procedures specified pursuant to section 1833(i)(1)(A) which are performed in the area, or, at the discretion of the Secretary (and except as provided in section 1164(b)(4)) a sample of such procedures.”

Contracts.

42 USC 1395l.
42 USC
1320c-13.

(e) COINSURANCE AND DEDUCTIBLE TO APPLY WITHOUT REGARD TO SETTING OF AMBULATORY SURGERY.—

(1) Clauses (i) and (ii) of section 1832(a)(2)(F) of the Social Security Act (42 U.S.C. 1395k(a)(2)(F)) are each amended by inserting “standard overhead” before “amount”.

(2)(A) Section 1833(b) of such Act (42 U.S.C. 1395l(b)) is amended by striking paragraph (3) and redesignating paragraphs (4) and (5) as paragraphs (3) and (4).

(B) Subparagraphs (A) and (B) of section 1833(i)(2) of such Act are each amended by inserting “80 percent of” before “a standard overhead amount”.

(f) DEVELOPMENT OF PROSPECTIVE PAYMENT METHODOLOGY FOR OUTPATIENT HOSPITAL SERVICES.—Section 1135 of the Social Security Act (42 U.S.C. 1320b-5) is amended by adding at the end the following new subsection:

“(d)(1) The Secretary shall develop a fully prospective payment system for ambulatory surgical procedures performed on patients in hospitals on an outpatient basis.

“(2) The system shall, to the extent practicable, provide for an all-inclusive payment rate for ambulatory surgical procedures performed on patients in hospitals on an outpatient basis, which rate encompasses payment for facility services and all medical and other health services, other than physicians’ services, commonly furnished in connection with such procedures.

“(3) The system shall provide for appropriate payment rates with respect to such procedures.

“(4) Such rates shall take into account at least the following considerations:

“(A) The costs of hospitals providing ambulatory surgical procedures.

“(B) The costs under this title of payment for such procedures performed in ambulatory surgical centers.

“(C) The extent to which any differences in such costs are justifiable.

“(5) The Secretary shall submit to Congress—

“(A) an interim report on the development of the system by April 1, 1988, and

“(B) a final report on such system by April 1, 1989.

Reports.

The report under subparagraph (B) shall include recommendations concerning the implementation of the payment system for ambulatory surgical procedures performed on or after October 1, 1989.

“(6)(A) The Secretary shall develop a model system for the payment for outpatient hospital services other than ambulatory surgery.

“(B) The Secretary shall submit to Congress a report on the model payment system under subparagraph (A) by January 1, 1991.”

Reports.

(g) REPORTING OF OPD SERVICES USING HCPCS.—Not later than July 1, 1987, each fiscal intermediary which processes claims under part B of title XVIII of the Social Security Act shall require hospitals, as a condition of payment for outpatient hospital services

Claims.
42 USC 1395u
note.
42 USC 1395j.

under that part, to report claims for payment for such services under such part using a HCFA Common Procedure Coding System.

42 USC 1395/
note.

(h) **EFFECTIVE DATES.**—

(1) The amendments made by subsection (a)(1) shall apply to cost reporting periods beginning on or after October 1, 1987.

(2) The amendments made by subsections (b)(1) and (d) shall apply to services furnished after June 30, 1987.

(3) The Secretary of Health and Human Services shall first provide, under the amendment made by subsection (b)(2), for the review and update of procedure lists within 6 months after the date of the enactment of this Act.

Contracts.

(4) The amendments made by subsection (c) shall apply to contracts entered into or renewed after January 1, 1987.

SEC. 9344. TECHNICAL AMENDMENTS AND MISCELLANEOUS PROVISIONS RELATING TO PART B.

(a) **ADDITIONAL MEMBERS FOR PHYSICIAN PAYMENT REVIEW COMMISSION.**—

(1) **2 ADDITIONAL MEMBERS.**—Section 1845(a)(2) of the Social Security Act (42 U.S.C. 1395w-1(a)(2)) is amended by striking “11 individuals” and inserting “13 individuals”.

42 USC 1395w-1
note.

(2) **APPOINTMENT OF ADDITIONAL MEMBERS.**—The Director of the Congressional Office of Technology Assessment shall appoint the two additional members of the Physician Payment Review Commission, as required by the amendment made by paragraph (1), no later than 60 days after the date of the enactment of this Act, for terms of 3 years, except that the Director may provide initially for such terms as will insure that (on a continuing basis) the terms of no more than five members expire in any one year.

(b) **EFFECTIVE DATE OF VOLUNTARY DISENROLLMENT FROM MEDICARE.**—

42 USC 1395q.

(1) **IN GENERAL.**—The second and sixth sentences of section 1838(b) of the Social Security Act (42 U.S.C. 1395p(b)) are each amended by striking “calendar quarter following the calendar quarter” and inserting “month following the month”.

42 USC 1395q
note.

(2) **EFFECTIVE DATE.**—The amendments made by paragraph (1) shall apply to notices filed on or after July 1, 1987.

(c) **STUDY ON PROSPECTIVE PAYMENT OF RADIOLOGY, ANESTHESIA, AND PATHOLOGY SERVICES TO HOSPITAL INPATIENTS.**—The Secretary of Health and Human Services shall study and report to Congress by July 1, 1987, concerning the design and implementation of a prospective payment system for payment, under part B of title XVIII of the Social Security, for radiology, anesthesia, and pathology services furnished to hospital inpatients. Such report shall include data, from a representative sample, showing, for discharges classified within each diagnosis-related group, the distribution of total reasonable charges and costs for each inpatient discharge for such services.

42 USC 1395b-1
note.

Ante, p. 194.

(d) **PREVENTIVE HEALTH SERVICES DEMONSTRATION PROGRAM.**—Effective as if included in section 9314 of the Consolidated Omnibus Budget Reconciliation Act of 1985 when such section was enacted, such section is amended—

Rural areas.

(1) in subsection (c)(2), by inserting “(at least one of which shall serve a rural area)” after “five sites”, and

(2) by striking the last sentence of subsection (f) and inserting the following: “Funding for the administrative costs of the

demonstration program shall not exceed \$5,900,000 over the duration of the program.”.

PART 4—IMPROVED REVIEW OF QUALITY BY PEER REVIEW ORGANIZATIONS

SEC. 9351. PRO REVIEW OF HOSPITAL DENIAL NOTICES.

(a) IN GENERAL.—Section 1154 of the Social Security Act (42 U.S.C. 1320c-3), as amended by section 9343(d)(2) of this subtitle, is amended by adding at the end the following new subsection:

“(e)(1) If—

“(A) a hospital has determined that a patient no longer requires inpatient hospital care, and

“(B) the attending physician has agreed with the hospital’s determination,

Physicians.

the hospital may provide the patient (or the patient’s representative) with a notice (meeting conditions prescribed by the Secretary under section 1879) of the determination.

Ante, p. 1991.

“(2) If—

“(A) a hospital has determined that a patient no longer requires inpatient hospital care, but

“(B) the attending physician has not agreed with the hospital’s determination,

the hospital may request the appropriate peer review organization to review under subsection (a) the validity of the hospital’s determination.

“(3)(A) If a patient (or a patient’s representative)—

“(i) has received a notice under paragraph (1), and

“(ii) requests the appropriate peer review organization to review the determination,

then, the organization shall conduct a review under subsection (a) of the validity of the hospital’s determination and shall provide notice (by telephone and in writing) to the patient or representative and the hospital and attending physician involved of the results of the review. Such review shall be conducted regardless of whether or not the hospital will charge for continued hospital care or whether or not the patient will be liable for payment for such continued care.

“(B) If a patient (or a patient’s representative) requests a review under subparagraph (A) while the patient is still an inpatient in the hospital and not later than noon of the first working day after the date the patient receives the notice under paragraph (1), then—

“(i) the hospital shall provide to the appropriate peer review organization the records required to review the determination by the close of business of such first working day, and

Records.

“(ii) the peer review organization must provide the notice under subparagraph (A) by not later than one full working day after the date the organization has received the request and such records.

“(4) If—

“(A) a request is made under paragraph (3)(A) not later than noon of the first working day after the date the patient (or patient’s representative) receives the notice under paragraph (1), and

“(B) the conditions described in section 1879(a)(2) with respect to the patient or representative are met,

the hospital may not charge the patient for inpatient hospital services furnished before noon of the day after the date the patient or representative receives notice of the peer review organization's decision.

42 USC 1320c-3
note.

"(5) In any review conducted under paragraph (2) or (3), the organization shall solicit the views of the patient involved (or the patient's representative)."

(b) **EFFECTIVE DATE.**—(1) Except as provided in paragraph (2), the amendment made by subsection (a) shall apply to denial notices furnished by hospitals to individuals on or after the first day of the first month that begins more than 30 days after the date of the enactment of this Act.

(2) Section 1154(e)(4) of the Social Security Act (as added by the amendment made by subsection (a)) shall take effect on the date of the enactment of this Act.

SEC. 9352. PRO REVIEW OF INPATIENT HOSPITAL SERVICES AND EARLY READMISSION CASES.

(a) **TIMELY PROVISION OF HOSPITAL INFORMATION.**—(1) Section 1153 of the Social Security Act (42 U.S.C. 1320c-2) is amended by adding at the end the following new subsection:

42 USC 1320c-3.

"(g) The Secretary shall provide that fiscal intermediaries furnish to peer review organizations, each month on a timely basis, data necessary to initiate the review process under section 1154(a) on a timely basis. If the Secretary determines that a fiscal intermediary is unable to furnish such data on a timely basis, the Secretary shall require the hospital to do so."

Contracts.

42 USC 1320c.

(2) Section 1816(a) of such Act (42 U.S.C. 1395h(a)) is amended by adding at the end the following: "As used in this title and part B of title XI, the term 'fiscal intermediary' means an agency or organization with a contract under this section."

Ante, p. 196.

(b) **REQUIRING REVIEW OF EARLY READMISSION CASES.**—Section 1154(a) of such Act (42 U.S.C. 1320c-3(a)), as amended by section 9401(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985, is amended by adding at the end the following new paragraph:

"(13) Notwithstanding paragraph (4), the organization shall perform the review described in paragraph (1) with respect to early readmission cases to determine if the previous inpatient hospital services and the post-hospital services met professionally recognized standards of health care. Such reviews may be performed on a sample basis if the organization and the Secretary determine it to be appropriate. In this paragraph, an 'early readmission case' is a case in which an individual, after discharge from a hospital, is readmitted to a hospital less than 31 days after the date of the most recent previous discharge."

42 USC 1320c-2
note.

(c) **EFFECTIVE DATES.**—(1) The Secretary of Health and Human Services shall implement the amendment made by subsection (a) not later than 6 months after the date of the enactment of this Act.

Contracts.
42 USC 1320c-3
note.

(2) The amendment made by subsection (b) shall apply to contracts entered into or renewed on or after January 1, 1987, except that in applying such amendment before January 1, 1989, the term "post-hospital services" does not include physicians' services, other than physicians' services furnished in a hospital, other inpatient facility, ambulatory surgical center, or rural health clinic.

SEC. 9353. PRO REVIEW OF QUALITY OF CARE.

(a) **REQUIRING PRO REVIEW OF QUALITY OF CARE.**—

(1) **ALLOCATION OF FUNDS FOR QUALITY CARE REVIEW.**—Section 1154(a)(4) of the Social Security Act (42 U.S.C. 1320c-3(a)(4)) is amended by adding at the end the following: “Each peer review organization shall provide that a reasonable proportion of its activities are involved with reviewing, under paragraph (1)(B), the quality of services and that a reasonable allocation of such activities is made among the different cases and settings (including post-acute-care settings, ambulatory settings, and health maintenance organizations). In establishing such allocation, the organization shall consider (i) whether there is reason to believe that there is a particular need for reviews of particular cases or settings because of previous problems regarding quality of care, (ii) the cost of such reviews and the likely yield of such reviews in terms of number and seriousness of quality of care problems likely to be discovered as a result of such reviews, and (iii) the availability and adequacy of alternative quality review and assurance mechanisms.”.

(2) **REQUIRING REVIEW OF HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.**—Such section is further amended—

(A) by inserting “(A)” after “(4)”;

(B) by adding at the end the following new subparagraph:

“(B) The contract of each organization shall provide for the review of services (including both inpatient and outpatient services) provided by eligible organizations pursuant to a contract under section 1876 for the purpose of determining whether the quality of such services meets professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings. The previous sentence shall not apply with respect to a contract year if another entity has been awarded a contract under subparagraph (C).”;

Contracts.

42 USC 1395mm.

(C) by adding at the end of such subparagraph the following: “Under the contract the level of effort expended by the organization on reviews under this subparagraph shall be equivalent, on a per enrollee basis, to the level of effort expended by the organization on utilization and quality reviews performed with respect to individuals not enrolled with an eligible organization.”; and

Contracts.

(D) by adding at the end the following additional new subparagraph:

“(C) The Secretary may provide, by contract under competitive procurement procedures on a State-by-State basis in up to 25 States, for the review described in subparagraph (B) by an appropriate entity (which may be a peer review organization described in that subparagraph). In selecting among States in which to conduct such competitive procurement procedures, the Secretary may not select States which, as a group, have more than 50 percent of the total number of individuals enrolled with eligible organizations under section 1876. Under a contract with an entity under this subparagraph—

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State and local
governments.

“(i) the entity must be, or must meet all the requirements under section 1152 to be, a utilization and quality control peer review organization,

42 USC 1320c-1.

“(ii) the contract must meet the requirement of section 1153(b)(3), and

42 USC 1320c-2.

“(iii) the level of effort expended under the contract shall be, to the extent practicable, not less than the level of effort that would otherwise be required under the third sentence of subparagraph (B) if this subparagraph did not apply.”.

(3) IDENTIFICATION OF METHODS FOR IDENTIFYING CASES OF SUBSTANDARD CARE.—Section 1154 of such Act (42 U.S.C. 1320c-3), as amended by sections 9343(d)(2) and 9351(a), is amended by adding at the end the following new subsection:

“(f) The Secretary, in consultation with appropriate experts, shall identify methods that would be available to assist peer review organizations (under subsection (a)(4)) in identifying those cases which are more likely than others to be associated with a quality of services which does not meet professionally recognized standards of health care.”.

(4) SMALL-AREA ANALYSIS.—The Secretary of Health and Human Services shall provide, to at least 12 utilization and quality control peer review organizations with contracts under part B of title XI of the Social Security Act, data and data processing assistance to allow each of these organizations to review and analyze small-area variations, in the service area of the organization, in the utilization of hospital and other health care services for which payment is made under title XVIII of such Act.

(5) CONFORMING AMENDMENT.—Section 9405 of the Consolidated Omnibus Budget Reconciliation Act of 1986 is amended by striking “January” and inserting “April”.

(6) EFFECTIVE DATES.—(A)(i) Except as provided in clause (ii), the amendments made by paragraphs (1) and (2)(D) shall apply to contracts as of January 1, 1987.

(ii) The amendment made by paragraph (1) shall not be construed as requiring, before January 1, 1989, the review of physicians’ services, other than physicians’ services furnished in a hospital, other inpatient facility, ambulatory surgical center, or rural health clinic.

(B) The amendment made by paragraph (2)(B) shall apply to contracts as of April 1, 1987.

(C) The amendment made by paragraph (2)(C) shall apply to review activities conducted by organizations on or after January 1, 1988.

(D) The amendment made by paragraph (3) becomes effective on the date of the enactment of this Act.

(b) REQUIRING CONSUMER REPRESENTATIVE ON PEER REVIEW BOARDS.—

(1) IN GENERAL.—Section 1152 of such Act (42 U.S.C. 1320c-1) is amended—

(A) by striking “and” at the end of paragraph (1),

(B) by striking the period at the end of paragraph (2) and inserting “; and”, and

(C) by adding at the end the following new paragraph:

“(3) has at least one individual who is a representative of consumers on its governing body.”.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to contracts entered into or renewed on or after January 1, 1987.

(c) IMPROVING PEER REVIEW RESPONSIVENESS TO BENEFICIARY COMPLAINTS.—

42 USC 1320c-3
note.

42 USC 1320c.

42 USC 1395.
42 USC 1320c-3
note.

Contracts.
42 USC 1320c-3
note.

Contracts.

Contracts.
42 USC 1320c-1
note.

(1) APPROPRIATE REVIEW OF COMPLAINTS REQUIRED.—Section 1154(a) of such Act (42 U.S.C. 1320c-3(a)), as amended by section 9352(b), is further amended by adding at the end the following new paragraph:

“(14) The organization shall conduct an appropriate review of all written complaints about the quality of services (for which payment may otherwise be made under title XVIII) not meeting professionally recognized standards of health care, if the complaint is filed with the organization by an individual entitled to benefits for such services under such title (or a person acting on the individual’s behalf). The organization shall inform the individual (or representative) of the organization’s final disposition of the complaint. Before the organization concludes that the quality of services does not meet professionally recognized standards of health care, the organization must provide the practitioner or person concerned with reasonable notice and opportunity for discussion.”.

42 USC 1395.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to complaints received on or after the first day of the first month that begins more than 9 months after the date of the enactment of this Act.

42 USC 1320c-3 note.

(d) SHARING OF INFORMATION BY PEER REVIEW ORGANIZATIONS.—

(1) IN GENERAL.—Subparagraph (C) of section 1160(b)(1) of such Act (42 U.S.C. 1320c-9(b)(1)) is amended to read as follows:

“(C) to assist appropriate State agencies recognized by the Secretary as having responsibility for licensing or certification of providers or practitioners or to assist national accreditation bodies acting pursuant to section 1865 in accrediting providers for purposes of meeting the conditions described in title XVIII, which data and information shall be provided by the peer review organization to any such agency or body at the request of such agency or body relating to a specific case or to a possible pattern of substandard care, but only to the extent that such data and information are required by the agency or body to carry out its respective function which is within the jurisdiction of the agency or body under State law or under section 1865;”.

State and local governments.

42 USC 1395bb.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to requests for data and information made on and after the end of the 6-month period beginning on the date of the enactment of this Act.

42 USC 1320c-9 note.

(e) FUNDING OF ADDITIONAL PRO ACTIVITIES.—

(1) THROUGH AGREEMENTS WITH HOSPITALS, SKILLED NURSING FACILITIES, AND HOME HEALTH AGENCIES.—Section 1866(a) of such Act (42 U.S.C. 1395cc(a)) is amended—

(A) in paragraph (1)(F)—

(i) by redesignating clauses (i), (ii), and (iii), as subclauses (I), (II), and (III), respectively,

(ii) by inserting “(i)” after “(F)”, and

(iii) by adding at the end the following new clause:

“(ii) in the case of hospitals, skilled nursing facilities, and home health agencies, to maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the hospital, facility, or agency is located) to perform the functions described in paragraph (4)(A);” and

Contracts.

42 USC 1320c.

(B) by adding at the end the following new paragraph:

“(4)(A) Under the agreement required under paragraph (1)(F)(ii), the peer review organization must perform functions (other than those covered under an agreement under paragraph (1)(F)(i)) under the third sentence of section 1154(a)(4)(A) and under section 1154(a)(14) with respect to services, furnished by the hospital, facility, or agency involved, for which payment may be made under this title.

“(B) For purposes of payment under this title, the cost of such an agreement to the hospital, facility, or agency shall be considered a cost incurred by such hospital, facility, or agency in providing covered services under this title and shall be paid directly by the Secretary to the peer review organization on behalf of such hospital, facility, or agency in accordance with a schedule established by the Secretary.

“(C) Such payments—

“(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

“(ii) shall not be less in the aggregate for hospitals, facilities, and agencies for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations’ conducting the activities described in subparagraph (A) with respect to such hospitals, facilities, or agencies under part B of title XI.”

42 USC 1320c.

(2) THROUGH AGREEMENTS WITH HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.—Section 1876(i) of such Act (42 U.S.C. 1395mm(i)), as amended by section 9312(f) of this subtitle, is amended by adding at the end the following new paragraph:

“(7)(A) Except as provided under section 1154(a)(4)(C), each risk-sharing contract with an eligible organization under this section shall provide that the organization will maintain an agreement with a utilization and quality control peer review organization (which has a contract with the Secretary under part B of title XI for the area in which the eligible organization is located) under which the peer review organization will perform functions under section 1154(a)(4)(B) and section 1154(a)(14) (other than those performed under contracts described in section 1866(a)(1)(F)) with respect to services, furnished by the eligible organization, for which payment may be made under this title.

42 USC 1395cc.

“(B) For purposes of payment under this title, the cost of such agreement to the eligible organization shall be considered a cost incurred by a provider of services in providing covered services under this title and shall be paid directly by the Secretary to the peer review organization on behalf of such eligible organization in accordance with a schedule established by the Secretary.

“(C) Such payments—

“(i) shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and from the Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries, and

“(ii) shall not be less in the aggregate for such organizations for a fiscal year than the amounts the Secretary determines to be sufficient to cover the costs of such organizations’ conducting activities described in subparagraph (A) with respect to such eligible organizations under part B of title XI.”

42 USC 1320c.

(3) EFFECTIVE DATE.—

(A) HOSPITALS, SKILLED NURSING FACILITIES, AND HOME HEALTH AGENCIES.—The amendments made by paragraph (1) shall apply to provider agreements as of October 1, 1987.

42 USC 1395cc note.

(B) HMOs AND CMPS.—The amendment made by paragraph (2) shall apply to risk-sharing contracts with eligible organizations, under section 1876 of the Social Security Act, as of April 1, 1987.

Contracts.
42 USC 1395mm note.
42 USC 1395mm.

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PART 1—COVERAGE OF INDIVIDUALS

SEC. 9401. OPTIONAL COVERAGE OF POOR PREGNANT WOMEN, INFANTS, AND CHILDREN.

(a) CREATION OF NEW OPTIONAL CATEGORICALLY NEEDY GROUP.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(1) by striking “, or” at the end of subclause (VII) and inserting a semicolon,

(2) by inserting “or” at the end of subclause (VIII), and

(3) by adding at the end the following new subclause:

“(IX) subject to subsection (1)(4), who are described in subsection (1)(I);”.

(b) DESCRIPTION OF GROUP.—Section 1902 of such Act is amended by inserting after subsection (k) the following new subsection:

“(1)(I) Individuals described in this paragraph are—

“(A) women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy),

“(B) infants under one year of age,

“(C) children who have attained one year of age but have not attained two years of age,

“(D) children who have attained two years of age but have not attained three years of age,

“(E) children who have attained three years of age but have not attained four years of age, and

“(F) children who have attained four years of age but have not yet attained five years of age,

who are not described in subsection (a)(10)(A)(i), whose family income does not exceed the income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.

“(2) For purposes of paragraph (1), the State shall establish an income level which is a percentage (not more than 100 percent) of the nonfarm income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

“(3) Notwithstanding subsection (a)(17), for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(ii)(IX)—

“(A) application of a resource standard shall be at the option of the State;

“(B) any resource standard or methodology that is applied with respect to an individual described in subparagraph (A) of paragraph (1) may not be more restrictive than the resource standard or methodology that is applied under title XVI;

“(C) any resource standard or methodology that is applied with respect to an individual described in subparagraph (B), (C), (D), (E), or (F) of paragraph (1) may not be more restrictive than the corresponding methodology that is applied under the State plan under part A of title IV;

“(D) the income standard to be applied is the income standard established under paragraph (2); and

“(E) family income shall be determined in accordance with the methodology employed under the State plan under part A

State and local
governments.

42 USC 9902.

42 USC 1381.

42 USC 601.

or E of title IV, and costs incurred for medical care or for any other type of remedial care shall not be taken into account. Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.

42 USC 670.

“(4)(A) A State plan may not elect the option of furnishing medical assistance to individuals described in subsection (a)(10)(A)(ii)(IX) unless the State has in effect, under its plan established under part A of title IV, payment levels that are not less than the payment levels in effect under its plan on April 17, 1986.

State and local governments.

“(B)(i) A State may not elect, under subsection (a)(10)(A)(ii)(IX), to cover only individuals described in paragraph (1)(A) or to cover only individuals described in paragraph (1)(B).

“(ii) A State may not elect, under subsection (a)(10)(A)(ii)(IX), to cover individuals described in subparagraph (C), (D), (E), or (F) of paragraph (1) unless the State has elected, under such subsection, to cover individuals described in the preceding subparagraphs of such paragraph.”.

(c) LIMITED BENEFITS FOR NEWLY ELIGIBLE PREGNANT WOMEN.—Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended, in the matter after subparagraph (D)—

(1) by striking “and” before “(VI)”, and

(2) by inserting before the semicolon at the end the following: “, and (VII) the medical assistance made available to an individual described in subsection (1)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, and postpartum services) and to other conditions which may complicate pregnancy”.

(d) CONTINUATION OF MEDICAL ASSISTANCE FOR CERTAIN PREGNANT WOMEN DURING PREGNANCY AND FOR CERTAIN INFANTS AND CHILDREN RECEIVING INPATIENT SERVICES.—Section 1902(e) of such Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following new paragraphs:

“(6) At the option of a State, if a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX), the plan may provide that any woman described in such subsection and subsection (1)(1)(A) shall continue to be treated as an individual described in subsection (a)(10)(A)(ii)(IX) without regard to any change in income of the family of which she is a member until the end of the 60-day period beginning on the last day of her pregnancy.

State and local governments.

“(7) If a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX), in the case of an infant or child described in subparagraph (B), (C), (D), (E), or (F) of subsection (1)(1)—

“(A) who is receiving inpatient services for which medical assistance is provided on the date the infant or child attains the maximum age with respect to which coverage is provided under the State plan for such individuals, and

“(B) who, but for attaining such age, would remain eligible for medical assistance under such subsection, the infant or child shall continue to be treated as an individual described in subsection (a)(10)(A)(ii)(IX) and subsection (1)(1) until the end of the stay for which the inpatient services are furnished.”.

(e) CONFORMING AMENDMENTS.—

(1) Section 1902(a)(17) of such Act (42 U.S.C. 1396(a)(17)) is amended by inserting "except as provided in subsection (l)(3)," after "(17)".

(2) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting "for any individual described in section 1902(a)(10)(A)(ii)(IX) or" after "as medical assistance".

42 USC 1396a
note.

(f) EFFECTIVE DATES.—

(1) Except as provided in paragraph (2), the amendments made by this section shall apply to medical assistance furnished in calendar quarters beginning on or after April 1, 1987.

(2)(A) Subparagraph (C) of section 1902(l)(1) of the Social Security Act, as added by subsection (b) of this section, shall apply to medical assistance furnished in calendar quarters beginning on or after October 1, 1987.

(B) Subparagraph (D) of section 1902(l)(1) of the Social Security Act, as added by subsection (b) of this section, shall apply to medical assistance furnished in calendar quarters beginning on or after October 1, 1988.

(C) Subparagraph (E) of section 1902(l)(1) of the Social Security Act, as added by subsection (b) of this section, shall apply to medical assistance furnished in calendar quarters beginning on or after October 1, 1989.

(D) Subparagraph (F) of section 1902(l)(1) of the Social Security Act, as added by subsection (b) of this section, shall apply to medical assistance furnished in calendar quarters beginning on or after October 1, 1990.

(3) An amendment made by this section shall become effective as provided in paragraph (1) or (2) without regard to whether or not final regulations to carry out such amendment have been promulgated by the applicable date.

SEC. 9402. OPTIONAL COVERAGE OF ELDERLY AND DISABLED POOR FOR ALL MEDICAID BENEFITS.

(a) CREATION OF NEW OPTIONAL CATEGORICALLY NEEDY GROUPS.—

(1) **IN GENERAL.**—Subsection (a)(10)(A)(ii) of section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 9401(a) of this subtitle, is amended—

(A) by striking "or" at the end of subclause (VIII),

(B) by striking the semicolon at the end of subclause (IX) and inserting ", or", and

(C) by adding at the end the following new subclause:
"(X) subject to subsection (m)(3), who are described in subsection (m)(1);".

(2) **DESCRIPTION OF INDIVIDUALS.**—Section 1902 of such Act is further amended by adding after subsection (l), as added by section 9401(b) of this subtitle, the following new subsection:
"(m)(1) Individuals described in this paragraph are individuals—

"(A) who are 65 years of age or older or are disabled individuals (as determined under section 1614(a)(3)),

"(B) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed an income level established by the State consistent with paragraph (2)(A), and

"(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed (except as provided in paragraph (2)(B)) the maximum

42 USC 1382c.
State and local
governments.
42 USC 1382a.

42 USC 1382b.

amount of resources that an individual may have and obtain benefits under that program.

“(2)(A) The income level established under paragraph (1)(B) may not exceed a percentage (not more than 100 percent) of the nonfarm official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

42 USC 9902.

“(B) In the case of a State that provides medical assistance to individuals not described in subsection (a)(10)(A) and at the State's option, the State may use under paragraph (1)(C) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in subsection (a)(10)(A).”

State and local governments.

(b) **REQUIREMENT OF COVERAGE OF CERTAIN PREGNANT WOMEN AND CHILDREN AND OTHER SPECIAL RULES.**—Section 1902(m) of such Act, as added by subsection (a)(2), is further amended by adding at the end the following new paragraphs:

42 USC 1396a.

“(3) A State plan may not provide coverage for individuals under subsection (a)(10)(A)(ii)(X), unless the plan provides coverage of some or all of the individuals described in subsection (1)(1).

State and local governments.

“(4) Notwithstanding subsection (a)(17), for individuals described in paragraph (1) who are covered under the State plan by virtue of subsection (a)(10)(A)(ii)(X)—

“(A) the income standard to be applied is the income standard described in paragraph (1)(B), and

“(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

42 USC 1382a.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.”

(c) **EFFECTIVE DATE.**—The amendments made by this section shall apply to payments to States for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

State and local governments.
42 USC 1396a note.

SEC. 9403. OPTIONAL COVERAGE OF POOR MEDICARE BENEFICIARIES FOR MEDICARE COST-SHARING EXPENSES.

(a) **ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARY.**—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended—

42 USC 1396a.

(1) by striking “and” at the end of subparagraph (C),

(2) by inserting “and” at the end of subparagraph (D), and

(3) by inserting after subparagraph (D) the following new subparagraph:

“(E) at the option of a State, but subject to subsection (m)(3), for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3)) for qualified medicare beneficiaries described in section 1905(p)(1);”

State and local governments.

42 USC 1396d.

(b) **QUALIFIED MEDICARE BENEFICIARY DEFINED.**—Section 1905 of such Act (42 U.S.C. 1396d) is amended by adding at the end the following new subsection:

“(p)(1) The term ‘qualified medicare beneficiary’ means an individual—

- 42 USC 1395c.
42 USC 1395i-2.
- State and local governments.
42 USC 1382a.
- 42 USC 1382b.
- “(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818),
- “(B) who, but for section 1902(a)(10)(E) and the election of the State, is not eligible for medical assistance under the plan,
- “(C) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed an income level established by the State consistent with paragraph (2)(A), and
- “(D) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed (except as provided in paragraph (2)(B)) the maximum amount of resources that an individual may have and obtain benefits under that program.
- “(2)(A) The income level established under paragraph (1)(C) may not exceed a percentage (not more than 100 percent) of the nonfarm official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.
- 51 USC 9902.
- State and local governments.
- “(B) In the case of a State that provides medical assistance to individuals not described in section 1902(a)(10)(A) and at the State’s option, the State may use under paragraph (1)(D) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in section 1902(a)(10)(A).”
- 42 USC 1396a.
- (c) **LIMITED, MEDICARE GAP-FILLING BENEFITS.**—Section 1902(a)(10) of such Act (42 U.S.C. 1395a(a)(10)), as amended by section 9401(c) of this subtitle and by subsection (a) of this section, is amended, in the matter after subparagraph (E)—
- (1) by striking “and” before “(VII)”, and
- (2) by inserting before the semicolon at the end the following:
- “, and (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1905(p)(1) shall be limited to medical assistance for medicare cost-sharing (described in section 1905(p)(3)), subject to the provisions of subsection (n) and section 1916(b)”.
- 42 USC 1396d.
- 42 USC 1396o.
- (d) **MEDICARE COST-SHARING DEFINED.**—Section 1905(p) of such Act, as added by subsection (b), is amended by adding at the end the following:
- “(3) The term ‘medicare cost-sharing’ means the following costs incurred with respect to a qualified medicare beneficiary:
- “(A) Premiums under part B and (if applicable) under section 1818.
- “(B) Deductibles and coinsurance described in section 1813.
- “(C) The annual deductible described in section 1833(b).
- “(D) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to ‘80 percent’ therein were deemed a reference to ‘100 percent’.
- Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876.”
- 42 USC 1395mm.
- (e) **PAYMENT AMOUNTS.**—Section 1902 of such Act, as amended by sections 9401(b) and 9402(a)(2) of this subtitle, is further amended by adding at the end the following new subsection:

“(n) In the case of medical assistance furnished under this title for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under title XVIII with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.”

State and local governments.

42 USC 1395.

(f) REQUIREMENT OF COVERAGE OF CERTAIN PREGNANT WOMEN AND CHILDREN AND OTHER SPECIAL RULES.—

42 USC 1396a.

(1) REQUIRING COVERAGE OF CERTAIN PREGNANT WOMEN AND CHILDREN AND INCOME STANDARD TO BE USED.—Section 1902(m) of such Act, as added by section 9402(a)(2) of this subtitle, and as amended by section 9402(b) of this subtitle, is amended—

(A) in paragraph (3), by inserting “or coverage under subsection (a)(10)(E)” after “subsection (a)(10)(A)(ii)(IX)”, and

(B) by adding at the end the following new paragraph:

“(5) Notwithstanding subsection (a)(17), for qualified medicare beneficiaries described in section 1905(p)(1)—

42 USC 1396d.

“(A) the income standard to be applied is the income standard described in section 1905(p)(1)(C), and

“(B) except as provided in section 1612(b)(4)(B)(ii), costs incurred for medical care or for any other type of remedial care shall not be taken into account in determining income.

42 USC 1382a.

Any different treatment provided under this paragraph for such individuals shall not, because of subsection (a)(17), require or permit such treatment for other individuals.”

(2) EFFECTIVE DATE OF BENEFITS.—Section 1902(e) of such Act, as amended by section 9401(d) of this subtitle, is amended by adding at the end the following new paragraph:

“(8) If an individual is determined to be a qualified medicare beneficiary (as defined in section 1905(p)(1)), such determination shall apply to services furnished after the end of the month in which the determination first occurs. For purposes of payment to a State under section 1903(a), such determination shall be considered to be valid for an individual for a period of 12 months, except that a State may provide for such determinations more frequently, but not more frequently than once every 6 months for an individual.”

State and local governments.

42 USC 1396b.

(g) CONFORMING AMENDMENTS.—

(1) TREATMENT OF BENEFITS.—Section 1902(a)(10)(C) of such Act (42 U.S.C. 1396a(a)(10)(C)) is amended, in the matter before clause (i), by inserting “or (E)” after “subparagraph (A)”.

(2) PAYMENT OF MEDICARE PREMIUMS AND PART A DEDUCTIBLE.—Section 1903(a)(1) of such Act (42 U.S.C. 1396b(a)(1)) is amended—

(A) by inserting “deductible amounts under part A and” after “(including expenditures for”,

(B) by inserting “(and, in the case of qualified medicare beneficiaries described in section 1905(p)(1), part A)” after “premiums under part B”, and

(C) by striking “or (B)” and inserting “(B) are qualified medicare beneficiaries described in section 1905(p)(1), or (C)”.

(3) **TIMING OF BENEFITS.**—Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended, in the matter before subdivision (i), by inserting “or, in the case of a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary” after “makes application for assistance”.

(4) **COPAYMENTS.**—

(A) Section 1902(a)(15) of such Act (42 U.S.C. 1396a(a)(15)) is amended by inserting “are not qualified medicare beneficiaries (as defined in section 1905(p)(1)) but” after “older who”.

(B) Subsections (a) and (b) of section 1916 of such Act (42 U.S.C. 1396o) are each amended by striking “section 1902(a)(10)(A)” and inserting “subparagraph (A) or (E) of section 1902(a)(10)”.

(h) **EFFECTIVE DATE.**—The amendments made by this section apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 9404. MEDICAID ELIGIBILITY FOR QUALIFIED SEVERELY IMPAIRED INDIVIDUALS.

(a) **AS CATEGORICALLY NEEDY.**—Section 1902(a)(10)(A)(i)(II) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended by inserting “or who are qualified severely impaired individuals (as defined in section 1905(q))” after “title XVI”.

(b) **DESCRIPTION OF QUALIFIED SEVERELY IMPAIRED INDIVIDUALS.**—Section 1905 of such Act (42 U.S.C. 1396d), as amended by section 9403(b) of this subtitle, is amended by adding at the end the following new subsection:

“(q) The term ‘qualified severely impaired individual’ means an individual under age 65—

“(1) who for the month preceding the first month to which this subsection applies to such individual—

“(A) received (i) a payment of supplemental security income benefits under section 1611(b) on the basis of blindness or disability, (ii) a supplementary payment under section 1616 of this Act or under section 212 of Public Law 93-66 on such basis, (iii) a payment of monthly benefits under section 1619(a), or (iv) a supplementary payment under section 1616(c)(3), and

“(B) was eligible for medical assistance under the State plan approved under this title; and

“(2) with respect to whom the Secretary determines that—

“(A) the individual continues to be blind or continues to have the disabling physical or mental impairment on the basis of which he was found to be under a disability and, except for his earnings, continues to meet all non-disability-related requirements for eligibility for benefits under title XVI,

“(B) the income of such individual would not, except for his earnings, be equal to or in excess of the amount which would cause him to be ineligible for payments under section 1611(b) (if he were otherwise eligible for such payments),

42 USC 1396a
note.
42 USC 1396.

42 USC 1382.

42 USC 1382e.
42 USC 1382
note.
42 USC 1382h.

State and local
governments.

42 USC 1381.

“(C) the lack of eligibility for benefits under this title would seriously inhibit his ability to continue or obtain employment, and

“(D) the individual’s earnings are not sufficient to allow him to provide for himself a reasonable equivalent of the benefits under title XVI (including any federally administered State supplementary payments), this title, and publicly funded attendant care services (including personal care assistance) that would be available to him in the absence of such earnings.

State and local governments.

42 USC 1381.

In the case of an individual who is eligible for medical assistance pursuant to section 1619(b) in June, 1987, the individual shall be a qualified severely impaired individual for so long as such individual meets the requirements of paragraph (2).”

42 USC 1382h.

(c) **EFFECTIVE DATE.**—(1) The amendments made by this section apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1987, without regard to whether regulations to implement such amendments are promulgated by such date.

42 USC 1396a note.

42 USC 1396.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

State and local governments.

SEC. 9405. CLARIFICATION OF ELIGIBILITY OF HOMELESS INDIVIDUALS.

Section 1902(b)(2) of the Social Security Act (42 U.S.C. 1396a(b)(2)) is amended by inserting before the semicolon the following: “, regardless of whether or not the residence is maintained permanently or at a fixed address”.

SEC. 9406. PAYMENT FOR ALIENS UNDER MEDICAID.

(a) **IN GENERAL.**—Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end thereof the following new subsection:

“(v)(1) Notwithstanding the preceding provisions of this section, except as provided in paragraph (2), no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

State and local governments.

“(2) Payment shall be made under this section for care and services that are furnished to an alien described in paragraph (1) only if—

“(A) such care and services are necessary for the treatment of an emergency medical condition of the alien, and

“(B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this title (other than the requirement of the receipt of aid or assistance under title IV, supplemental security income benefits under title XVI, or a State supplementary payment).

42 USC 601.

42 USC 1381.

“(3) For purposes of this subsection, the term ‘emergency medical condition’ means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

“(A) placing the patient’s health in serious jeopardy,

“(B) serious impairment to bodily functions, or

“(C) serious dysfunction of any bodily organ or part.”.

State and local
governments.

(b) **CONFORMING AMENDMENT.**—Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended by adding at the end thereof the following new sentence: “Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law only in accordance with section 1903(v).”.

42 USC 1396a
note.

(c) **EFFECTIVE DATE.**—

(1) Except as provided in paragraph (2), the amendments made by this section shall apply to medical assistance furnished to aliens on or after January 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

42 USC 1396.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendment made in subsection (b), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

SEC. 9407. OPTIONAL PRESUMPTIVE ELIGIBILITY PERIOD FOR PREGNANT WOMEN.

(a) **STATE OPTION.**—Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended—

(1) by striking “and” at the end of paragraph (45),

(2) by striking the period at the end of paragraph (46) and inserting in lieu thereof “; and”, and

(3) by adding at the end the following:

“(47) at the option of the State, provide for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1920.”.

(b) **PRESUMPTIVE ELIGIBILITY.**—Title XIX of the Social Security Act is amended by redesignating section 1920 as section 1921 and inserting after section 1919 the following new section:

42 USC 1396s.

“PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

42 USC 1396r-1.

“SEC. 1920. (a) A State plan approved under section 1902 may provide for making ambulatory prenatal care available to a pregnant woman during a presumptive eligibility period.

“(b) For purposes of this section—

“(1) the term ‘presumptive eligibility period’ means, with respect to a pregnant woman, the period that—

“(A) begins with the date on which a qualified provider determines, on the basis of preliminary information, that the family income of the woman does not exceed the applicable income level of eligibility under the State plan, and

“(B) ends with (and includes) the earlier of—

“(i) the day on which a determination is made with respect to the eligibility of the woman for medical assistance under the State plan,

“(ii) the day that is 45 days after the date on which the provider makes the determination referred to in subparagraph (A), or

“(iii) in the case of a woman who does not file an application for medical assistance within 14 calendar days after the date on which the provider makes the determination referred to in subparagraph (A), the fourteenth calendar day after such determination is made; and

“(2) the term ‘qualified provider’ means any provider that—

“(A) is eligible for payments under a State plan approved under this title,

“(B) provides services of the type described in subparagraph (A) or (B) of section 1905(a)(2) or in section 1905(a)(9),

“(C) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A), and

“(D)(i) receives funds under—

“(I) section 329 or section 330 of the Public Health Service Act, or

“(II) title V of this Act;

“(ii) participates in a program established under—

“(I) section 17 of the Child Nutrition Act of 1966, or

“(II) section 4(a) of the Agriculture and Consumer Protection Act of 1973; or

“(iii) participates in a State perinatal program.

“(c)(1) The State agency shall provide qualified providers with—

“(A) such forms as are necessary for a pregnant woman to make application for medical assistance under the State plan, and

“(B) information on how to assist such women in completing and filing such forms.

“(2) A qualified provider that determines under subsection (b)(1)(A) that a pregnant woman is presumptively eligible for medical assistance under a State plan shall—

“(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

“(B) inform the woman at the time the determination is made that she is required to make application for medical assistance under the State plan within 14 calendar days after the date on which the determination is made.

“(3) A pregnant woman who is determined by a qualified provider to be presumptively eligible for medical assistance under a State plan shall make application for medical assistance under such plan within 14 calendar days after the date on which the determination is made.

42 USC 1396d.

42 USC 254b,
254e.

42 USC 701.

42 USC 1786.

42 USC 1446a.

“(d) Notwithstanding any other provision of this title, ambulatory prenatal care that—

“(1) is furnished to a pregnant woman—

“(A) during a presumptive eligibility period,

“(B) by a qualified provider; and

“(2) is included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1903.”

42 USC 1396b.

(c) CONFORMING CHANGE.—Section 1903(u)(1)(D) of such Act (42 U.S.C. 1396b(u)(1)(D)) is amended by adding at the end the following:

“(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1920(b)(1)).”

Ante, p. 2058.

42 USC 1396a
note.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to ambulatory prenatal care furnished in calendar quarters beginning on or after April 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 9408. RESPIRATORY CARE SERVICES FOR VENTILATOR-DEPENDENT INDIVIDUALS.

(a) REQUIRED SERVICES.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396b(e)), as amended by sections 9401(d) and 9403(f) of this subtitle, is further amended by adding at the end the following new paragraph:

42 USC 1396a.

State and local
governments.

“(9)(A) At the option of the State, the plan may include as medical assistance respiratory care services for any individual who—

“(i) is medically dependent on a ventilator for life support at least six hours per day;

“(ii) has been so dependent for at least 30 consecutive days (or the maximum number of days authorized under the State plan, whichever is less) as an inpatient;

Hospitals.

“(iii) but for the availability of respiratory care services, would require respiratory care as an inpatient in a hospital, skilled nursing facility, or intermediate care facility, and would be eligible to have payment made for such inpatient care under the State plan;

“(iv) has adequate social support services to be cared for at home; and

“(v) wishes to be cared for at home.

“(B) The requirements of subparagraph (A)(ii) may be satisfied by a continuous stay in one or more hospitals, skilled nursing facilities, or intermediate care facilities.

“(C) For purposes of this paragraph, respiratory care services means services provided on a part-time basis in the home of the individual by a respiratory therapist or other health care professional trained in respiratory therapy (as determined by the State), payment for which is not otherwise included within other items and services furnished to such individual as medical assistance under the plan.”

(b) WAIVER OF COMPARABILITY.—Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)), as amended by sections 9401(c), 9403(a), and

9403(c) of this subtitle, is further amended, in the matter following subparagraph (E)—

(1) by striking “and” before “(VIII)”; and

(2) by inserting before the semicolon at the end thereof the following: “, and (IX) the making available of respiratory care services in accordance with subsection (e)(9) shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A), provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection”.

(c) CONFORMING CHANGES.—

(1) Section 1905(a) of the Social Security Act (42 U.S.C. 1395d(a)), as amended by section 1895(c)(3) of the Tax Reform Act of 1986, is further amended—

Ante, p. 2931.

(A) by striking “and” at the end of paragraph (19),

(B) by redesignating paragraph (20) as paragraph (21), and

(C) by inserting after paragraph (19) the following new paragraph:

“(20) respiratory care services (as defined in section 1902(e)(9)(C)); and”.

Ante, p. 2060.

(2) Section 1902(j) of the Social Security Act (42 U.S.C. 1396a(j)), as amended by section 1895(c)(3) of the Tax Reform Act of 1986, is amended by striking “(20)” and inserting in lieu thereof “(21)”.

(3) Section 1902(a)(10)(C)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(C)(iv)), as amended by section 1895(c)(3) of the Tax Reform Act of 1986, is amended by striking “through (19)” and inserting in lieu thereof “through (20)”.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after the date of the enactment of this Act.

42 USC 1396a note.

PART 2—PROVISION OF SERVICES UNDER WAIVER AUTHORITY

SEC. 9411. PERMITTING STATES TO OFFER HOME AND COMMUNITY-BASED SERVICES TO CERTAIN LOW-INCOME INDIVIDUALS.

(a) WAIVER AUTHORITY.—

Hospitals.

(1) Section 1915(c)(1) of the Social Security Act (42 U.S.C. 1396n(c)(1)) is amended—

(A) by inserting “a hospital or” after “level of care provided in”, and

(B) by striking out all beginning with “or but for” through “State plan” the third place it appears.

(2) Section 1915(c)(2)(B) of such Act is amended—

(A) in clause (i) by striking “skilled nursing facility or” and inserting in lieu thereof “inpatient hospital, skilled nursing facility, or”, and

(B) in the matter following clause (iii) by inserting “inpatient hospital,” after “need for”.

(3) Section 1915(c)(7) of such Act is amended to read as follows:

“(7) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with a particular illness or

condition who are inpatients in hospitals or in skilled nursing or intermediate care facilities, the State may determine the average per capita expenditure that would have been made in a fiscal year for those individuals under the State plan separately from the expenditures for other individuals who are inpatients of those respective facilities.”.

State and local
governments.
Acquired
immune
deficiency
syndrome.
42 USC 1396n.

(b) **PROVIDING CASE MANAGEMENT SERVICES TO PATIENTS WITH CERTAIN CONDITIONS.**—Section 1915(g)(1) of such Act is amended by adding at the end the following: “A State may limit the provision of case management services under this subsection to individuals with acquired immune deficiency syndrome (AIDS), or with AIDS-related conditions, or with either, and a State may limit the provision of case management services under this subsection to individuals with chronic mental illness.”.

Ante, pp. 203,
204.
42 USC 1396a.

(c) **WAIVER OF COMPARABILITY REQUIREMENT.**—The first sentence of section 1915(c)(3) of such Act is amended by striking all that follows “statewideness”) and inserting “and section 1902(a)(10)(B) (relating to comparability).”.

(d) **PROVIDING CERTAIN OTHER SERVICES TO PATIENTS WITH CHRONIC MENTAL ILLNESS.**—Section 1915(c)(4)(B) of such Act is amended by inserting before the period at the end the following: “and for day treatment or other partial hospitalization services, psychosocial rehabilitation services, and clinic services (whether or not furnished in a facility) for individuals with chronic mental illness”.

42 USC 1396n
note.

(e) **EFFECTIVE DATE.**—The amendments made by this section shall apply to applications for waivers (or renewals thereof) approved on or after the date of the enactment of this Act.

SEC. 9412. WAIVER AUTHORITY FOR CHRONICALLY MENTALLY ILL AND FRAIL ELDERLY.

(a) **CHRONICALLY MENTALLY ILL DEMONSTRATION PROGRAM.**—

State and local
governments.
42 USC 1396.

(1) The Secretary of Health and Human Services may, in accordance with this subsection, waive certain provisions of title XIX of the Social Security Act in order to allow States to implement demonstration programs to improve the continuity, quality, and cost-effectiveness of mental health services available to chronically mentally ill medicaid beneficiaries.

(2) A waiver shall be granted under this subsection with respect to a demonstration program only if—

Grants.

(A) the demonstration program has been awarded a grant from the Robert Wood Johnson Foundation and the Department of Housing and Urban Development under their “Program for the Chronically Mentally Ill”,

(B) the State provides assurances satisfactory to the Secretary that under such waiver—

(i) the average per capita expenditure estimated by the State in any fiscal year for medical assistance for mental health services provided with respect to individuals covered under the program does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such services for such individuals if the waiver had not been granted, and

(ii) there will be no reduction or limitation in benefits to a medicaid beneficiary under the program.

(3) The authority under this subsection extends only to the following, as they relate to the provision of mental health services:

(A) A waiver of the requirements of sections 1902(a)(1), 1902(a)(10)(B), 1902(a)(23), and 1902(a)(30) and clauses (i) and (ii) of section 1903(m)(2) of the Social Security Act.

42 USC 1396a,
1396b.

(B) Including as "medical assistance" under the State plan case management services with respect to mentally ill patients, habilitation services (as defined in section 1915(c)(5) of such Act), day treatment or other partial hospitalization services, residential services (other than room and board), psychosocial rehabilitation services, clinic services (whether or not furnished in a facility), and such other services as the State may request and the Secretary may approve for individuals covered under the demonstration project.

42 USC 1396n.

(4)(A) A waiver under this subsection shall be for an initial term of three years which may be extended for an additional two-year term. The request of a State for extension of such a waiver shall be deemed granted unless the Secretary denies such request in writing within 90 days after the date of its submission to the Secretary.

(B) The authority to approve a waiver under this subsection extends only during the five-year period beginning on October 1, 1986.

(5) Subsections (c)(6) and (e)(1) of section 1915 of the Social Security Act shall apply to a waiver under this subsection in the same manner as they apply to a waiver under that section.

(6) The Secretary shall report, not later than January 1, 1993, to Congress on the cost, accessibility, utilization, and quality of services provided under waivers granted under this subsection.

Reports.

(b) FRAIL ELDERLY DEMONSTRATION PROJECT WAIVERS.—

(1) The Secretary of Health and Human Services shall grant waivers of certain requirements of titles XVIII and XIX of the Social Security Act to not more than 10 public or nonprofit private community-based organizations to enable such organizations to provide comprehensive health care services on a capitated basis to frail elderly patients at risk of institutionalization.

42 USC 1395,
1396.

(2)(A) Except as provided in subparagraph (B), the terms and conditions of a waiver granted pursuant to this subsection shall be substantially the same as the terms and conditions of the On Lok waiver (referred to in section 603(c) of the Social Security Amendments of 1983 and extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985).

42 USC 1395b-1
notes.
Ante, p. 183.
Grants.

(B) In order to receive a waiver under this subsection, an organization must be awarded a grant from the Robert Wood Johnson Foundation.

(C) Subject to subparagraph (B), any waiver granted pursuant to this subsection shall be for an initial period of 3 years. The Secretary may extend such waiver beyond such initial period for so long as the Secretary finds that the organization complies with the terms and conditions described in subparagraphs (A) and (B).

SEC. 9413. CONTINUATION OF "CASE-MANAGED MEDICAL CARE FOR NURSING HOME PATIENTS" DEMONSTRATION PROJECT.

Massachusetts.

42 USC 1395,
1396.

42 USC 1315.

(a) **APPROVAL OF APPLICATION.**—The Secretary of Health and Human Services shall approve any application for a waiver of any requirement of title XVIII or XIX of the Social Security Act necessary to provide for continuation, from July 1, 1987, through June 30, 1989, of the "Case-Managed Medical Care for Nursing Home Patients" demonstration project (#95-P-98346/1-01) carried out pursuant to section 222 of the Social Security Amendments of 1972, section 402 of the Social Security Amendments of 1967, and section 1115 of the Social Security Act by the Department of Public Welfare, Commonwealth of Massachusetts.

(b) **TERMS AND CONDITIONS.**—The Secretary's approval of an application (or renewal of an application) under subsection (a) shall be on the same terms and conditions as applied to the demonstration project on July 1, 1986.

SEC. 9414. NEW JERSEY RESPITE CARE PILOT PROJECT.

Disabled
persons.
Aged persons.

(a) **ESTABLISHMENT.**—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall enter into an agreement with the State of New Jersey (in this section referred to as the "State") for the purpose of conducting a pilot project (in this section referred to as the "project") under title XIX of the Social Security Act for providing respite care services for elderly and disabled individuals in order to determine the extent to which—

(1) the provision of necessary respite care services to individuals at risk of institutionalization will delay or avert the need for institutional care, and

(2) respite care services enhance and sustain the role of the family in providing long-term care services for elderly and disabled individuals at risk of institutionalization.

Contracts.

(b) **CONDITIONS.**—The agreement with the Secretary under this section shall—

State and local
governments.

(1) provide that the project shall be administered by a State health services agency designated for such purpose by the Governor (which may be the State agency administering or responsible for the administration of the State plan for medical assistance under title XIX of the Social Security Act),

42 USC 1396.

(2) provide that if the project imposes any cost sharing requirements on participants who are eligible for benefits under title XIX of the Social Security Act, such requirements shall be imposed only in accordance with the provisions of section 1916 of such Act,

42 USC 1396o.

(3) provide for a system of review to assure that respite care services are provided only to individuals reasonably determined to be in need of such services, and

(4) meet such other requirements as the Secretary may establish for the proper and efficient implementation of the project.

(c) **DEFINITION.**—For purposes of this section, the term "respite care services" shall include—

(1) short-term and intermittent—

(A) companion or sitter services (paid as well as volunteer),

(B) homemaker and personal-care services,

(C) adult day care, and

(D) inpatient care in a hospital, a skilled nursing facility, or an intermediate care facility (not to exceed a total of 14 days for any individual); and

(2) peer support and training for family caregivers (using informal support groups and organized counseling).

(d) **PAYMENTS.**—The agreement under this section shall be entered into between the Secretary and the State agency designated by the Governor. Under such agreement the Secretary shall pay to the State, as in additional payment under section 1903 of the Social Security Act for each quarter, an amount equal to 50 percent of the reasonable costs incurred by such State during such quarter in providing respite care services under the project for elderly and disabled individuals who are eligible for medical assistance under the State plan approved under title XIX of such Act (or who would be eligible if coverage under such plan was as broad as allowed under Federal law). The Federal payment shall not exceed \$1,000,000 for fiscal year 1987, and \$2,000,000 for each of the fiscal years 1988, 1989, and 1990. No payments shall be made pursuant to this section for any fiscal year beginning after September 30, 1990.

Contracts.
State and local
governments.
Aged persons.
Disabled
persons.
42 USC 1396b.

42 USC 1396.

(e) **DURATION.**—The project under this section shall be of a maximum duration of four years, plus an additional time period of up to six months for final evaluation and reporting.

Reports.

(f) **REPORTS.**—The State shall arrange for an independent evaluation of the project and shall transmit the evaluation to the Secretary not more than six months after the conclusion of project.

(g) **PROVISIONS SUBJECT TO WAIVER.**—At the request of the State, the Secretary shall waive the following provisions of title XIX of the Social Security Act as they relate to the pilot project: section 1902(a)(1), section 1902(a)(10)(B), section 1902(a)(13), and section 1902(a)(30). The Secretary may not waive any other provision of such title with respect to the pilot project.

42 USC 1396a.

SEC. 9415. INAPPLICABILITY OF PAPERWORK REDUCTION ACT.

Notwithstanding any other provision of law, chapter 35 of title 44, United States Code, shall not apply to information required to carry out any provision of this part or the amendments made by this part.

44 USC 3501 *et seq.*

PART 3—PAYMENTS

SEC. 9421. HOLDING STATES HARMLESS IN FISCAL YEAR 1987 AGAINST A DECREASE IN THE FEDERAL MEDICAL ASSISTANCE PERCENTAGE.

(a) **IN GENERAL.**—Section 9528 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by adding at the end the following new subsection:

42 USC 1301
note.
Ante, p. 1972.

“(c) **HOLD HARMLESS PROVISION.**—Notwithstanding subsection (b), for calendar quarters occurring during fiscal year 1987 and only for purposes of making payment to a State under section 1903 of the Social Security Act, the amendments made by subsection (a) shall not apply to a State if the effect of the applying the amendments would be to reduce the amount of payment made to the State under that section.”

42 USC 1396b.

(b) **EFFECTIVE DATE.**—The amendment made by subsection (a) shall be effective as though it had been included in the Consolidated Omnibus Budget Reconciliation Act of 1985 at the time of its enactment.

42 USC 1301
note.
Ante, p. 82.

SEC. 9422. WAIVER OF CERTAIN REQUIREMENTS.

Notwithstanding the three-month limitation set forth in sections 1902(a)(34) and 1905(a) of the Social Security Act, payment may be

South Carolina.
42 USC 1396a,
1396d.

42 USC 1396.

made under title XIX of such Act with respect to care and services provided by the Medical University of South Carolina, after September 30, 1984, and before July 1, 1985, to individuals—

42 USC 1396a.

Women.

State and local governments.

(1) who are not described in section 1902(a)(10)(A) of such Act, (2) who, upon application, would have been eligible as individuals under the age of 18 or pregnant women, for medical assistance under the State plan approved under such title at the time such care and services were provided, and

(3) who, not later than six months after the date of the enactment of this Act, are determined by the State agency administering or supervising the administration of such plan to have been so eligible.

PART 4—OTHER QUALITY AND EFFICIENCY MEASURES

SEC. 9431. INDEPENDENT QUALITY REVIEW OF HMO SERVICES.

(a) **IN GENERAL.**—Section 1902(a)(30) of the Social Security Act (42 U.S.C. 1396a(a)(30)) is amended—

(1) by inserting “and” at the end of subparagraph (B), and (2) by adding at the end the following new subparagraph:

Contracts.
State and local
governments.
42 USC 1320c.

“(C) provide a utilization and quality control peer review organization (under part B of title XI) or a private accreditation body to conduct (on an annual basis) an independent, external review of the quality of services furnished under each contract under section 1903(m), with the results of such review made available to the State and, upon request, to the Secretary, the Inspector General in the Department of Health and Human Services, and the Comptroller General;”.

42 USC 1396b.

(b) **CONFORMING AMENDMENTS.**—(1) Section 1902(d) of such Act (42 U.S.C. 1396a(d)) is amended by inserting “(including quality review functions described in subsection (a)(30)(C))” after “medical or utilization review functions”.

(2) Section 1903(a)(3)(C) of such Act (42 U.S.C. 1396b(a)(3)(C)) is amended by inserting “or quality review” after “medical and utilization review”.

42 USC 1396a
note.

(c) **EFFECTIVE DATE.**—The amendments made by this section apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1987, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 9432. STATE UTILIZATION REVIEW SYSTEMS.

Hospitals.
42 USC 1396a
note.

(a) **IN GENERAL.**—The Secretary of Health and Human Services (in this section referred to as the “Secretary”) may not, during the period beginning with the date of the enactment of this Act and ending with the date that is 180 days after the day on which the report required by subsection (b) is submitted to the Congress, publish final or interim final regulations requiring a State plan approved under title XIX of the Social Security Act to include a program requiring second surgical opinions or a program of inpatient hospital preadmission review.

42 USC 1396.

(b) **REPORT.**—

(1) The Secretary shall report to Congress, by not later than October 1, 1988, for each State in a representative sample of States—

(A) the identity of those procedures which are high volume or high cost procedures among patients who are covered under the State medicaid plan,

(B) the payment rates under those plans for such procedures, and the aggregate annual payment amounts made under such plans for such procedures (including the Federal share of such payment amounts),

(C) the rate at which each such procedure is performed on medicaid patients and (to the extent that data are available) comparisons to the rate at which such procedure is performed on patients of comparable age who are not medicaid patients,

(D) with respect to each such procedure—

(i) the number of board certified or board eligible physicians in the State who provide care and services to medicaid patients and who perform the procedure, and Physicians.

(ii) in the case of a State with a mandatory second surgical opinion program in operation, the number of physicians described in clause (i) who provide second opinions (of the type described in section 1164 of the Social Security Act) for the procedure at prevailing payment rates under the State medicaid plan, and Ante, p. 196.

(E) in the case of a State with a mandatory second surgical opinion program or a program of inpatient hospital preadmission review in operation, a description of— Hospitals.

(i) the extent to which such program impedes access to necessary care and services, and

(ii) the measures that the State has taken to address such impediments, particularly in rural areas. Rural areas.

(2) Such report shall also include a list of those surgical procedures which the Secretary believes meet the following criteria and for which a mandatory second opinion program under medicaid plans may be appropriate:

(A) The procedure is one which generally can be postponed without undue risk to the patient.

(B) The procedure is a high volume procedure among patients who are covered under State medicaid plans or is a high cost procedure.

(C) The procedure has a comparatively high rate of nonconfirmation upon examination by another qualified physician, there is substantial geographic variation in the rates of performance of the procedure, or there are other reasons why requiring second opinions for 100 percent of such procedures would be cost effective. Physicians.

(3) The representative sample of States required to be included in the report shall include States with mandatory second surgical opinion programs in operation, States with programs of inpatient hospital preadmission review in operation, and States with neither such program in operation. Hospitals.

(4) In this subsection, the term "medicaid plan" means a State plan approved under title XIX of the Social Security Act. 42 USC 1396.

(c) STUDY.—

(1) The Secretary shall conduct a study of the utilization of selected medical treatments and surgical procedures by medicaid beneficiaries in order to assess the appropriateness, necessity, and effectiveness of such treatments and procedures.

(2) The study shall analyze the extent to which there is significant variation in the rate of utilization by medicaid bene-

ficiaries of selected treatments and procedures for different geographic areas within States and among States.

(3) The study shall also identify underutilized, medically necessary treatments and procedures for which—

(A) a failure to furnish could have an adverse effect on health status, and

(B) the rate of utilization by medicaid beneficiaries is significantly less than the rate for comparable, age-adjusted populations.

(4) The study shall be coordinated, to the extent practicable, with the research program established pursuant to section 1875(c) of the Social Security Act, with particular regard to the relationship of the variations described in paragraph (2) to patient outcomes.

(5) The Secretary shall report the results of the study to the Congress not later than January 1, 1990.

SEC. 9433. CLARIFICATION OF FLEXIBILITY FOR STATE MEDICAID PAYMENT SYSTEMS FOR INPATIENT SERVICES.

(a) IN GENERAL.—Section 2173 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35, 95 Stat. 809) is amended by adding at the end the following new subsection:

“(d) Section 1902 of such Act is further amended by inserting before subsection (i) the following new subsection:

“(h) Nothing in this title (including subsections (a)(13) and (a)(30) of this section) shall be construed as authorizing the Secretary to limit the amount of payment adjustments that may be made under a plan under this title with respect to hospitals that serve a disproportionate number of low-income patients with special needs.’”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply as though it was included in the enactment of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35).

SEC. 9434. FINANCIAL DISCLOSURE REQUIREMENTS FOR HMOS; CIVIL MONEY PENALTIES.

(a) DISCLOSURE OF INTERLOCKING RELATIONSHIPS.—

(1) Section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is amended—

(A) in paragraph (2)(A)—

(i) by striking “and” at the end of clause (vi),

(ii) by striking the period at the end of clause (vii) and inserting “, and”, and

(iii) by adding after clause (vii) the following new clause:

“(viii) such contract provides for disclosure of information in accordance with section 1124 and paragraph (4) of this subsection.”; and

(B) by adding at the end the following new paragraph:

“(4)(A) Each health maintenance organization which is not a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) must report to the State and, upon request, to the Secretary, the Inspector General of the Department of Health and Human Services, and the Comptroller General a description of transactions between the organization and a party in interest (as defined in section 1318(b) of such Act), including the following transactions:

Research and development.

Ante, p. 2006.

42 USC 1396a.

42 USC 1396a.

Hospitals.
Disadvantaged persons.

42 USC 1396a note.

95 Stat. 357.

Contracts.

42 USC 1320a-3.

Reports.

42 USC 300e-9.

42 USC 300e-17.

“(i) Any sale or exchange, or leasing of any property between the organization and such a party.

Gifts and property.

“(ii) Any furnishing for consideration of goods, services (including management services), or facilities between the organization and such a party, but not including salaries paid to employees for services provided in the normal course of their employment.

“(iii) Any lending of money or other extension of credit between the organization and such a party.

The State or Secretary may require that information reported respecting an organization which controls, or is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

State and local governments.

“(B) Each organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.”.

(2) Section 1903(m)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1396b(m)(2)(A)(iii)) is amended by inserting before the semicolon the following: “and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of \$100,000”.

Contracts.

(3)(A) The amendments made by paragraph (1) shall take effect 6 months after the date of the enactment of this Act.

Effective date.
Contracts.
42 USC 1396b note.

(B) The amendment made by paragraph (2) shall take effect on the date of the enactment of this Act and shall apply to contracts entered into, renewed, or extended after the end of the 30-day period beginning on the date of the enactment of this Act.

(b) CIVIL MONEY PENALTIES.—Section 1903(m) of the Social Security Act, as amended by subsection (a), is further amended by adding at the end the following new paragraph:

“(5)(A) Any entity with a contract under this subsection that fails substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under such contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals, is subject to a civil money penalty of not more than \$10,000 for each such failure.

Contracts.

“(B) The provisions of section 1128A (other than subsection (a)) shall apply to a civil money penalty under subparagraph (A) in the same manner as they apply to a civil money penalty under that section.”.

Ante, pp. 2003, 2008.

SEC. 9435. COBRA TECHNICAL CORRECTIONS AND CLARIFICATIONS RELATING TO THE MEDICAID PROGRAM.

(a) MAINTENANCE INCOME STANDARDS.—Section 9502(j)(4) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking out “on or after” and inserting in lieu thereof “before, on, or after”.

42 USC 1396n note.
Ante, p. 202.

(b) HOSPICE CARE FOR DUAL ELIGIBLES.—

(1) Section 1902(a)(13)(D) of the Social Security Act, as amended by sections 9505(c)(1) and 9509(a)(4) of the Consolidated Omnibus Budget Reconciliation Act of 1985, is amended by inserting before the first semicolon the following: “and for payment of amounts under section 1905(o)(3)”.

42 USC 1396a.
Ante, pp. 208, 211.
42 USC 1396d.

(2) Section 1905(o) of the Social Security Act, as amended by section 9505(a)(2) of the Consolidated Omnibus Budget Reconciliation Act of 1985, is amended by adding at the end the following new paragraph:

Ante, p. 208.

State and local governments.

“(3) In the case of a State which elects not to provide medical assistance for hospice care, but provides medical assistance for skilled nursing or intermediate care facility services with respect to an individual—

“(A) who is residing in a skilled nursing or intermediate care facility and is receiving medical assistance for services in such facility under the plan,

42 USC 1395c.

42 USC 1395d.

“(B) who is entitled to benefits under part A of title XVIII and has elected, under section 1812(d), to receive hospice care under such part, and

“(C) with respect to whom the hospice program under such title and the skilled nursing or intermediate care facility have entered into a written agreement under which the program takes full responsibility for the professional management of the individual's hospice care and the facility agrees to provide room and board to the individual, instead of any payment otherwise made under the plan with respect to the facility's services, the State shall provide for payment to the hospice program of an amount equal to the amounts allocated under the plan for room and board in the facility, in accordance with the rates established under section 1902(a)(13), and, if the individual is an individual described in section 1902(a)(10)(A), shall provide for payment of any coinsurance amounts imposed under section 1813(a)(4). For purposes of this paragraph and section 1902(a)(13)(D), the term ‘room and board’ includes performance of personal care services, including assistance in activities of daily living, in socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervising and assisting in the use of durable medical equipment and prescribed therapies.”.

42 USC 1396a.

42 USC 1395e.

42 USC 1396a note.

Ante, p. 210.

Handicapped persons.

(c) **MEDICAID QUALIFYING TRUSTS.**—Section 9506 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by adding at the end the following new subsection:

“(c) **EXCEPTION.**—The amendment made by subsection (a) shall not apply to any trust or initial trust decree established prior to April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.”.

(d) **EFFECTIVE DATES.**—

Ante, pp. 208, 210.

(1) Sections 9505(e) and 9508(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985 are each amended by inserting before the period at the end the following: “, without regard to whether or not regulations to carry out the amendments have been promulgated by that date”.

Ante, p. 212.

(2) Sections 9510(b) and 9511(b) of the Consolidated Omnibus Budget Reconciliation Act of 1985 are each amended by inserting before the period at the end the following: “, without regard to whether or not regulations to carry out the amendment have been promulgated by that date”.

42 USC 1396b note.

Ante, p. 2931.

(e) **HEALTH INSURING ORGANIZATIONS.**—Section 9517(c)(2) of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 1895(c)(4) of the Tax Reform Act of 1986, is amended by adding at the end the following new subparagraph:

“(D) Nothing in section 1903(m)(1)(A) of the Social Security Act shall be construed as requiring a health-insuring organization to be organized under the health maintenance organization laws of a State.”

State and local governments.
42 USC 1396b.

(f) **EFFECTIVE DATE.**—The amendments made by this section shall be effective as if included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985.

42 USC 1396a note.

Ante, p. 82.

SEC. 9436. PAYMENT FOR CERTAIN LONG-TERM CARE PATIENTS IN HOSPITALS.

(a) **IN GENERAL.**—In the case of a State which received a waiver under the authority of section 402(b) of the Social Security Amendments of 1967 with respect to payment methodology for inpatient hospital services under title XVIII and XIX of the Social Security Act during the 3-year period beginning January 1, 1983, notwithstanding section 1902(a)(13) of such Act, the State may pay under title XIX of such Act for hospital patients receiving services at an inappropriate level of care at the rate for hospital patients receiving an appropriate level of care if the Secretary of Health and Human Services determines that a sufficient number of hospital beds have been decertified in the State to reduce the payments to hospitals under such title in the State by amount equal to or greater than the amount by which payments to hospitals under such title in such State will increase as a result of the payment of such higher rates for patients receiving inappropriate levels of care.

State and local governments.
42 USC 1395b-1.
42 USC 1395, 1396.
42 USC 1396a.

(b) **EFFECTIVE PERIOD.**—Subsection (a) shall apply to payments for services furnished during the 3-year period beginning January 1, 1986, after the date the Secretary makes the determination described in that subsection.

PART 5—MATERNAL AND CHILD HEALTH

SEC. 9441. AUTHORIZATION AND ALLOTMENT OF ADDITIONAL FUNDS.

(a) **ADDITIONAL FUNDS.**—Section 501(a) of the Social Security Act (42 U.S.C. 701(a)) is amended by striking “\$478,000,000 for fiscal year 1984” and inserting “\$553,000,000 for fiscal year 1987, \$557,000,000 for fiscal year 1988, and \$561,000,000 for fiscal year 1989”.

(b) **ALLOTMENT OF ADDITIONAL APPROPRIATIONS.**—Section 502 of such Act (42 U.S.C. 702) is amended—

(1) in subsection (a)(1) by striking “amount appropriated under section 501(a)” and inserting in lieu thereof “amounts appropriated under section 501(a) for a fiscal year that are not in excess of \$478,000,000”;

(2) in subsection (b)—

(A) by inserting “that are not in excess of \$478,000,000” after “fiscal year” the first place it appears, and

(B) by striking paragraph (3); and

(3) by adding at the end the following new subsections:

“(c)(1) Of the amounts appropriated for a fiscal year in excess of \$478,000,000, an amount equal to 7 percent for fiscal year 1987, 8 percent for fiscal year 1988, and 9 percent for fiscal year 1989 shall be retained by the Secretary for the purpose of carrying out (through grants, contracts, or otherwise) projects for the screening of newborns for sickle-cell anemia and other genetic disorders. The provisions of paragraph (3) of subsection (a) shall apply to projects authorized by this paragraph to the same extent as such provisions apply to projects authorized under such subsection.

Grants.
Contracts.

“(2)(A) Of the amounts appropriated for a fiscal year in excess of \$478,000,000 that remain after the Secretary has retained the applicable amount (if any) for such fiscal year under paragraph (1), an amount equal to 33 $\frac{1}{3}$ percent shall be retained and allotted in the same manner as the amounts retained and allotted under subsections (a) and (b).

Research and
development.

“(B) The amounts retained by the Secretary under this paragraph shall be used for the purpose of carrying out (through grants, contracts, or otherwise) special projects of regional or national significance, training, and research to promote access to primary health services for children and community-based service networks and case management services for children with special health care needs.

State and local
governments.

“(C) The amounts allotted to the States under this paragraph shall be used to develop primary health services demonstration programs and projects for children and to promote the development of community-based service networks and case management services for children with special health care needs.

“(D) For purposes of this paragraph—

“(i) the term ‘primary health services’ includes—

“(I) any assessment, diagnosis, or treatment service provided on an outpatient basis that is designed to promote the health, to prevent the development of disease or disability, or to treat an illness or other health condition, of a child, and

“(II) any service designed to promote the access of children to high quality, continuous, and comprehensive primary health services, including case management;

“(ii) the term ‘community-based service network for children with special health care needs’ means a network of coordinated, high-quality services that is located in or near the home communities of children with special health care needs in order to improve the health status, functioning, and well-being of such children;

“(iii) the term ‘case management services’ means services to promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children and their families; and

“(iv) the term ‘comprehensive services’ includes early identification and intervention services, diagnostic and evaluation services, treatment services, rehabilitation services, family support services, and special education services.

“(3) Of the amounts appropriated for a fiscal year in excess of \$478,000,000 that remain after the Secretary has retained the applicable amount (if any) for such fiscal year under paragraph (1), an amount equal to 66 $\frac{2}{3}$ percent shall be retained and allotted in the same manner and for the same purposes as the amounts retained and allotted under subsections (a) and (b).

State and local
governments.

“(d)(1) To the extent that all the funds appropriated under this title for a fiscal year are not otherwise allotted to States either because all the States have not qualified for such allotments under section 505 for the fiscal year or because some States have indicated in their descriptions of activities under section 505 that they do not intend to use the full amount of such allotments, such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.

“(2) To the extent that all the funds appropriated under this title for a fiscal year are not otherwise allotted to States because some State allotments are offset under section 506(b)(2), such excess shall be allotted among the remaining States in proportion to the amount otherwise allotted to such States for the fiscal year without regard to this paragraph.”.

42 USC 706.

SEC. 9442. MATERNAL AND CHILD HEALTH AND ADOPTION CLEARINGHOUSE.

The Secretary of Health and Human Services shall establish, either directly or by grant or contract, a National Adoption Information Clearinghouse. The Clearinghouse shall—

Grants.
Contracts.
42 USC 679a.

(1) collect, compile, and maintain information obtained from available research, studies, and reports by public and private agencies, institutions, or individuals concerning all aspects of infant adoption and adoption of children with special needs;

(2) compile, maintain, and periodically revise directories of information concerning—

Women.
Education.
State and local
governments.

(A) crisis pregnancy centers,

(B) shelters and residences for pregnant women,

(C) training programs on adoption,

(D) educational programs on adoption,

(E) licensed adoption agencies,

(F) State laws relating to adoption,

(G) intercountry adoption, and

(H) any other information relating to adoption for pregnant women, infertile couples, adoptive parents, unmarried individuals who want to adopt children, individuals who have been adopted, birth parents who have placed a child for adoption, adoption agencies, social workers, counselors, or other individuals who work in the adoption field;

(3) disseminate the information compiled and maintained pursuant to paragraph (1) and the directories compiled and maintained pursuant to paragraph (2); and

(4) upon the establishment of an adoption and foster care data collection system pursuant to section 479 of the Social Security Act, disseminate the data and information made available through that system.

Infra.

SEC. 9443. COLLECTION OF DATA RELATING TO ADOPTION AND FOSTER CARE.

Part E of title IV of the Social Security Act, as amended by section 1883(b)(10) of the Tax Reform Act of 1986, is further amended by adding at the end thereof the following new section:

“COLLECTION OF DATA RELATING TO ADOPTION AND FOSTER CARE

“SEC. 479. (a)(1) Not later than 90 days after the date of the enactment of this subsection, the Secretary shall establish an Advisory Committee on Adoption and Foster Care Information (in this section referred to as the ‘Advisory Committee’) to study the various methods of establishing, administering, and financing a system for the collection of data with respect to adoption and foster care in the United States.

42 USC 679.

“(2) The study required by paragraph (1) shall—

“(A) identify the types of data necessary to—

“(i) assess (on a continuing basis) the incidence, characteristics, and status of adoption and foster care in the United States, and

“(ii) develop appropriate national policies with respect to adoption and foster care;

“(B) evaluate the feasibility and appropriateness of collecting data with respect to privately arranged adoptions and adoptions arranged through private agencies without assistance from public child welfare agencies;

“(C) assess the validity of various methods of collecting data with respect to adoption and foster care; and

“(D) evaluate the financial and administrative impact of implementing each such method.

Reports.

“(3) Not later than October 1, 1987, the Advisory Committee shall submit to the Secretary and the Congress a report setting forth the results of the study required by paragraph (1) and evaluating and making recommendations with respect to the various methods of establishing, administering, and financing a system for the collection of data with respect to adoption and foster care in the United States.

“(4)(A) Subject to subparagraph (B), the membership and organization of the Advisory Committee shall be determined by the Secretary.

State and local governments.

“(B) The membership of the Advisory Committee shall include representatives of—

“(i) private, nonprofit organizations with an interest in child welfare (including organizations that provide foster care and adoption services),

“(ii) organizations representing State and local governmental agencies with responsibility for foster care and adoption services,

“(iii) organizations representing State and local governmental agencies with responsibility for the collection of health and social statistics,

“(iv) organizations representing State and local judicial bodies with jurisdiction over family law,

“(v) Federal agencies responsible for the collection of health and social statistics, and

“(vi) organizations and agencies involved with privately arranged or international adoptions.

“(5) After the date of the submission of the report required by paragraph (3), the Advisory Committee shall cease to exist.

Reports.

“(b)(1)(A) Not later than July 1, 1988, the Secretary shall submit to the Congress a report that—

“(i) proposes a method of establishing, administering, and financing a system for the collection of data relating to adoption and foster care in the United States,

“(ii) evaluates the feasibility and appropriateness of collecting data with respect to privately arranged adoptions and adoptions arranged through private agencies without assistance from public child welfare agencies, and

“(iii) evaluates the impact of the system proposed under clause (i) on the agencies with responsibility for implementing it.

Reports.

“(B) The report required by subparagraph (A) shall—

“(i) specify any changes in law that will be necessary to implement the system proposed under subparagraph (A)(i), and

“(ii) describe the type of system that will be implemented under paragraph (2) in the absence of such changes.

“(2) Not later than December 31, 1988, the Secretary shall promulgate final regulations providing for the implementation of— Regulations.

“(A) the system proposed under paragraph (1)(A)(i), or

“(B) if the changes in law specified pursuant to paragraph (1)(B)(i) have not been enacted, the system described in paragraph (1)(B)(ii).

Such regulations shall provide for the full implementation of the system not later than October 1, 1991.

“(c) Any data collection system developed and implemented under this section shall—

“(1) avoid unnecessary diversion of resources from agencies responsible for adoption and foster care;

“(2) assure that any data that is collected is reliable and consistent over time and among jurisdictions through the use of uniform definitions and methodologies;

“(3) provide comprehensive national information with respect to—

“(A) the demographic characteristics of adoptive and foster children and their biological and adoptive or foster parents,

“(B) the status of the foster care population (including the number of children in foster care, length of placement, type of placement, availability for adoption, and goals for ending or continuing foster care),

“(C) the number and characteristics of—

“(i) children placed in or removed from foster care, and

“(ii) children adopted or with respect to whom adoptions have been terminated, and

“(D) the extent and nature of assistance provided by Federal, State, and local adoption and foster care programs and the characteristics of the children with respect to whom such assistance is provided; and State and local governments.

“(4) utilize appropriate requirements and incentives to ensure that the system functions reliably throughout the United States.”.

Subtitle F—Provision Relating to Access to Health Care

Sec. 9501. Continuation coverage for retirees in cases of bankruptcies.

SEC. 9501. CONTINUATION COVERAGE FOR RETIREES IN CASES OF BANKRUPTCIES.

(a) LOSS OF COVERAGE OF RETIREE THROUGH BANKRUPTCY AS QUALIFYING EVENT.—

(1) IRC AMENDMENT.—Paragraph (3) of section 162(k) of the Internal Revenue Code of 1986 (relating to qualifying event with respect to continuation coverage requirements under group health plans) is amended by adding at the end the following:

Post, p. 2095.
26 USC 162.

“(F) A proceeding in a case under title 11, United States Code, commencing on or after July 1, 1986, with respect to the employer from whose employment the covered employee retired at any time.

Employment
and
unemployment.

In the case of an event described in subparagraph (F), a loss of coverage includes a substantial elimination of coverage with

striking "or (4)" each place it appears and inserting in lieu thereof "(4), or (6)".

26 USC 162 note.

(e) EFFECTIVE DATE.—

Ante, p. 222.

(1) IN GENERAL.—The amendments made by this section shall take effect as if included in title X of the Consolidated Omnibus Budget Reconciliation Act of 1985.

Ante, pp. 222, 227.

(2) TREATMENT OF CERTAIN BANKRUPTCY PROCEEDINGS.—Notwithstanding paragraph (1), section 10001(e) of the Consolidated Omnibus Budget Reconciliation Act of 1985, and section 10002(d) of such Act, the amendments made by this section and by sections 10001 and 10002 of such Act shall apply in the case of plan years ending during the 12-month period beginning July 1, 1986, but only with respect to—

Ante, p. 2095.

Ante, p. 2076.

(A) a qualifying event described in section 162(k)(3)(F) of the Internal Revenue Code of 1986 or section 603(6) of the Employee Retirement Income Security Act of 1974, and

(B) a qualifying event described in section 162(k)(3)(A) of the Internal Revenue Code of 1986 or section 603(1) of the Employee Retirement Income Security Act of 1974 relating to the death of a retired employee occurring after the date of the qualifying event described in subparagraph (A).

(3) TREATMENT OF CURRENT RETIREES.—Section 162(k)(3)(F) of the Internal Revenue Code of 1986 and section 603(6) of the Employee Retirement Income Security Act of 1974 apply to covered employees who retired before, on, or after the date of the enactment of this Act.

Ante, p. 230.

Ante, p. 2077.

Post, p. 2095;
26 USC 162.

(4) NOTICE.—In the case of a qualifying event described in section 603(6) of the Employee Retirement Income Security Act of 1974 that occurred before the date of the enactment of this Act, the notice required under section 606(2) of such Act (and under section 162(k)(6)(B) of the Internal Revenue Code of 1986) with respect to such event shall be provided no later than 30 days after the date of the enactment of this Act.

Approved October 21, 1986.

LEGISLATIVE HISTORY—H.R. 5300 (S. 2706) (S. 2799):

HOUSE REPORTS: No. 99-727 (Comm. on the Budget) and No. 99-1012 (Comm. of Conference).

SENATE REPORTS: No. 99-348 accompanying S. 2706 (Comm. on the Budget) and No. 99-479 accompanying S. 2799 (Comm. on Environment and Public Works).

CONGRESSIONAL RECORD, Vol. 132 (1986):

Sept. 17-19, S. 2706 considered and passed Senate.

Sept. 24, H.R. 5300 considered and passed House.

Sept. 25, considered and passed Senate, amended, in lieu of S. 2706.

Sept. 27, S. 2799 considered and passed Senate.

Oct. 17, House and Senate agreed to conference report.

WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 22 (1986):

Oct. 21, Presidential statement.

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